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AIDS: Perspective on the American Family

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AIDS: PERSPECTIVE ON THE AMERICAN FAMILY

REV. RAYMOND C. O'BRIEN*

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I. INTRODUCTION

A. *AIDS and the Limit of Possibilities*

In 1981, Betty Friedan, author of *The Feminine Mystique* and both founder and first president of the National Organization for Women, wrote a new book which focused upon the family. She writes in her book, almost twenty years after her "catalytic work of the modern women's movement," that the failure of the movement was "our blind spot about the family."¹ In an effort to distinguish a particular definition of family and to address the failure, she suggests:

None of us can depend throughout our new long lives on that old nuclear family to meet our needs for nurture, love and support, but all of us still have those needs. The answer is not to deny them, but to recognize that equality makes it possible, and necessary, for *new* kinds of family. The answer is to recognize, strengthen or create new family forms that can sustain us now—and that will change, as our own needs change, over time.²

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1. B. FRIEDAN, *THE SECOND STAGE* 253 (1981). The author explains the movement's blind spot about the family:

It was our own extreme reaction against that wife-mother role: that devotional dependence on men and nurture of children and housewife service which has been and still is the source of power and status and identity, purpose and self-worth and economic security for so many women—even if it is not all that secure anymore.

Id. at 203.

2. *Id.* at 53.

The "life-strengthening possibilities opened by the women's movement"³ seemed limitless when Betty Friedan wrote *The Second Stage* in 1981.

But also in 1981, Michael Gottlieb's article about pneumocystis carinii pneumonia in homosexual men appeared in the *New England Journal of Medicine* and Alvin Friedman-Kien had an article on Kaposi's sarcoma in the same edition.⁴ These two events, the unlimited possibilities of *The Second Stage* and the discovery of symptoms that would come to be known as AIDS, all occurred in 1981 and all are interrelated.⁵

Decades will pass before sociologists will be able to comprehend the effect of the limitless possibilities of the sixties and seventies, the dynamism of human potential fostered in writers like Betty Friedan, or the human sexual revolution surrounding self. But any person reflecting on the changes accompanying the writings of authors like Ms. Friedan must admit that no one could have foreseen the impact upon human relationships by a virus that was so briefly described in that medical journal in 1981. Judicial decisions that pushed aside state laws concerning the family and replaced them with the federal constitution—*Griswold*, *Loving*, *Roe*, *Zablocki*—became less important as new articles and new headlines educated all to the dangers of sex and, by implication, limitless possibilities. Compelling state interests took on resurrected significance.

The problem is not that any person, group, or movement was wrong, rather, it is that the human potential movement and everyone else was caught by surprise when men and women began to die of a frightful disease for which no one had an explanation or cure. The tragic death of so many rebuts the presumption of limitless possibility most significantly because the disease originated in the most sacred as-

3. *Id.* at 40.

4. The publication of these articles in 1981 and the first official report on the outbreak of Kaposi's sarcoma in the *Morbidity and Mortality Report* of July 3, 1981, are seen as the first official recognition given to what would later become known as AIDS. See 30 CDC MORBIDITY & MORTALITY WEEKLY REP. 305 (1981). It is important to remember that by April 2, 1982 the disease had

struck 300 Americans and killed 119 . . . [t]he epidemic had . . . spread across nineteen states and seven countries. Of the 300 cases in the United States, 242 were gay or bisexual men, 30 were heterosexual men, 10 were heterosexual women, and 18 were men of unknown sexual orientation. Since intravenous drug transmission had yet to be proven scientifically, the cautious CDC statisticians had not yet roped off addicts as a separate risk group.

R. SHILTS, AND THE BAND PLAYED ON 138 (1987).

5. R. SHILTS, *supra* note 4, at 102. While the disease AIDS existed prior to 1981, that was the year that the Centers for Disease Control (CDC) established the Kaposi's Sarcoma and Opportunistic Infections (KSOI) Task Force, partially in response to statistics that indicated victims were identified solely on the basis of "how they identified themselves in social terms." *Id.* at 71.

pect of the newly achieved potential: sex. Friedan described this sexual essence in 1981:

[T]he more authentically a woman, or a man, is free to know, and become, herself or himself, the more surely, uniquely, she is *herself*, he is *himself*. The second stage is not unisex. It is human sex, for women as for men—active or passive, responsive, responsible, playful or profound, no longer an acting out of eroticized rage, or manipulation of covert power, joyless dues for economic support, or brutal revenge of love denied.⁶

When the changes concerning family law in America during the second half of the twentieth century are discussed, it seems certain that Betty Friedan's search for new human families which she announced as the second stage of her search for human equality, was—and will continue to be—affected by the nascent appearance of pandemic AIDS. Further, because AIDS is associated with human sex,⁷ and human sex is associated with freedom to know and discover new possibilities, any further discovery must be limited, regardless of any ethical, moral or humanistic claims.

This paper will focus on the probable impact of AIDS upon family law and family issues in America. Although it is still too early to tell precisely what effect AIDS will have in these areas, it is essential for lawyers and other professionals to begin a dialogue now in order to face the many challenges which lie ahead as the disease continues to spread and impact family relationships.

Among the many subjects discussed below is the likely trend that fear of infection and death will restrict the societal demand and acceptance of new definitions of family. In order to provide for security, monogamy is preferable and marriage, because it offers status and structure, follows. Within the marital home, the illusion of spousal unity will continue to retreat before the protective devices of torts, abuse, annulments, divorce and, where unity is preferred, a quest to obtain insurance, pensions, government benefits and medical assistance to preserve dignity and life. Whether in retreat from marriage for fear of infection, or security within marriage because of infection, the quest will be the same: economic security.

Also considered are the profound family law issues surrounding

6. B. FRIEDAN, *supra* note 1, at 321-22 (emphasis supplied by author).

7. Sexual contact and the sharing of contaminated I.V. drug needles are the two principal modes of transmission of the virus, yet the Human Immunodeficiency Virus (HIV) has been isolated "from blood, semen, saliva, tears, urine, cerebrospinal fluid, amniotic fluid, breast milk, cervical secretions, and tissue of infected persons." 1988 *Agent Summary Statement for Human Immunodeficiency Virus and Report on Laboratory-Acquired Infection with Human Immunodeficiency Virus*, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 3 (Supp. 1988) [hereinafter 1988 *Summary Statement*].

children—presumptions of best interest, primary caretaker, what the child would have enjoyed, the wishes of the child or enabling the child to thrive, custody and visitation, adoption, and termination of parental rights—all of which will continue to be affected by AIDS.

Finally discrimination, intrusive governmental compelling interests and the responsibility of professionals to respond seriously and creatively to the many challenges presented by AIDS will be discussed.

B. *The Problem: And the Band Played On*⁸

Everyone concerned about AIDS has become anesthetized by the numbers. The statistics are tabulated on a Model 277 Display computer in Room 274 of Building 6 at the Centers for Disease Control headquarters. Every week a crew of people categorize the deaths by risk group and geographical region,⁹ and every week the list is published in CDC's bulletin, *Morbidity and Mortality Weekly Report*. The *Report* for March 25, 1988 indicated 343 new AIDS cases reported that week; 6,229 for the first two and one-half months of 1988 (4,129 for the same period in 1987).¹⁰ New York accounted for one-sixth of the cases in 1988; states like California one-fifth, Texas and Florida one-fifteenth each.¹¹ Estimates concerning present HIV infection in the United States still remain between 1 million to 1.5 million persons and yet, "[c]urrent data show that substantial numbers of new infections continue to occur in all population groups except hemophiliacs and transfusion recipients."¹² The

8. Randy Shilts, author of *And the Band Played On*, is a gay journalist who has worked since 1982 for the *San Francisco Chronicle*, assigned full-time to cover AIDS. R. SHILTS, *supra* note 4, at 607.

9. *Id.* at 560. In 1985 Dale Lawrence of the CDC disclosed to the First International Conference on AIDS the statistics he had assembled in 1983: "[P]encils dropped and jaws gaped throughout the auditorium as Lawrence calmly laid out his projection that the mean incubation period for the AIDS virus was 5.5 years. Some people, he added, would not get AIDS until 14 years after their infection." *Id.* at 552.

10. 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 172-73 (1988). By November 26, 1988, there were 27,540 new cases, up from 18,192 new cases the same time the previous year. 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 722 (1988). The numbers are not infallible. Additions have been made to the symptoms classified with AIDS and there are instances of failure to report or misdiagnosis, intentional and non-intentional, even though reporting is required by law. See Hardy, Starcher, Morgan, Kristel, Day, Kelly, Ewing & Curran, *Review of Death Certificates to Assess Completeness of AIDS Case Reporting*, 102 U.S. PUB. HEALTH SERVICE, PUB. HEALTH REP. 386-91 (1987) (strictness of current case definition may have resulted in underestimating AIDS cases). See also Poterat, Phillips & Muth, *Lying to Military Physicians About Risk Factors for HIV Infections*, 257 J. A.M.A. 1727 (1987); Brookmeyer & Gail, *Minimum Size of the Acquired Immunodeficiency Syndrome (AIDS) Epidemic in the United States*, 2 LANCET 1320, 1320-22 (1986).

11. 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 173 (1988).

12. *Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge*, 36 CDC MORBIDITY & MORTALITY WEEKLY REP. 14 (1987) [hereinafter *Human Immunodeficiency*]. New York state health officials expect that the

available methods for estimating the total number of infected persons are imprecise and, according to the CDC, "cannot be considered definitive."¹³

Even if the numbers were exact and reporting completely verifiable, the general American population still seems anesthetized to them unless the figures can be attached to a name, a next door neighbor, a lover, a friend, a relative, or someone important.¹⁴ This seems to be perceived as a more accurate indication of the spread of the disease. It is a misleading and dangerous perception. Indeed, in the absence of societal victims the public goes beyond anesthetization by numbers and assumes that once the projected date of 1991 arrives and 1.5 million persons are diagnosed, there will be an end to the disease and the good times will return. This is not true. As one writer observes, "nothing says that there will not be further increases [in numbers] in 1992 and beyond in the absence of effective education about prevention."¹⁵

Perhaps the most clandestine danger inherent in ignoring numbers or relying chiefly on societal deaths is the fact that the disease is now targeting racial minorities, drug users, prostitutes and infants.¹⁶ If soci-

statewide AIDS death toll will have a sevenfold rise during the next five years. *New York Expects A Big Rise in AIDS*, N.Y. Times, Dec. 7, 1988, at B1.

13. *Human Immunodeficiency*, *supra* note 12, at 16-17.

14. Randy Shilts writes of how the death of identifiable persons from AIDS related complexes seizes public attention. During a hip replacement operation in July 1983, a sixty-six year old Roman Catholic nun, Sister Romana Marie Ryan was transfused with infected blood. She later died of AIDS. R. SHILTS, *supra* note 4, at 521. Shilts also writes that after the July 1985 announcement of Rock Hudson having AIDS, "[i]t took a square-jawed, heterosexually perceived actor like Rock Hudson to make AIDS something people could talk about. It took an ultra-conservative fundamentalist who looked like an Old Testament prophet to credibly call for all of America to take the epidemic seriously at last." *Id.* at 588. When Rock Hudson died on October 2, 1985, America's attention became riveted upon this deadly disease for the first time. *Id.* at xxi.

15. Osborn, *AIDS: Politics and Science*, 318 NEW ENG. J. MED. 444, 445 (1988). The elusive nature of the virus is again demonstrated in a recent discovery. In February 1988, a bone transplant recipient was diagnosed with AIDS after developing pneumocystis carinii pneumonia. The recipient had no known risk of HIV infection other than bone grafting, and the bone donor was subsequently found to have been infected with HIV. 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 597 (1988). See also Haseltine & Wong-Staal, *The Molecular Biology of the AIDS Virus*, 259 SCI. AM. 52 (1988); Marx, *Tracking Variation in the AIDS Virus Family*, 241 SCIENCE 659 (1988).

16. Adolescents are becoming a "vulnerable haven" for AIDS. Although only one percent of total AIDS cases are teen-agers, because teen-agers are more likely to be sexual adventurers and teen-agers also are often forgotten in drug programs, "the number of teen-agers with AIDS is doubling every year." *Adolescents: AIDS Epidemic's Next Hot Spot*, Wash. Post, May 17, 1988, at HE6, col. 1. According to Dr. Karen Hein, director of the Adolescent AIDS Program at Montefiore Medical Center in the Bronx, sexual activity with an infected male partner is the leading cause of AIDS among adolescent girls. *Id.* "Nationally, about 46 percent of teen-age girls with AIDS were infected from a sexual partner; in New York City, more than half—52 percent—contracted the disease through sexual activity." *Id.* See also *HIV-Related Beliefs, Knowledge, and Behaviors*

ety is seduced into thinking that the disease affects only one or more of these groups, society will not take the proper precautions to protect itself. The numbers are important because they call attention to education and prevention—especially for particular groups.

Where do the numbers seem to be taking us? Within what aspects of the American family are there likely to be effects that concomitantly cause judicial and legislative inquiry? What follows are parameters of the AIDS pandemic based on currently available information.

1. *Volume*

By the winter of 1988, nearly 81,000 cases of AIDS had been reported in the United States since 1981. Dr. James Curran, Director of the CDC's AIDS Program reports that "[n]ew cases [of AIDS] are being reported in the United States at the rate of one every 14 minutes and an estimated 365,000 cases will have been reported by 1992."¹⁷ To date, 84,256 cases have been reported from more than 136 countries,¹⁸ demonstrating both the extent of the disease in the United States, as well as the national active surveillance system.¹⁹ Based on present reporting to the Centers for Disease Control, since January 1, 1988, there are on an average 630 new cases in the United States each week. Furthermore, "[i]t is estimated that between 1 and 2 million individuals in the United States are infected with HIV and are at present without symptoms. Given the fact that approximately 20 to 30 percent of infected individuals will develop AIDS within 5 years of infection, it is projected that there will be 270,000 cumulative cases of AIDS [in the United States] by 1991."²⁰

These are present numbers and estimates, but any projection must take into account the impact of what shall follow. As Dr. June Osborn

Among High School Students, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 717, 718 (1988).

17. Wash. Post, June 14, 1988, at A14, col. 5.

18. *Update: Acquired Immunodeficiency Syndrome (AIDS)—Worldwide*, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 286 (1988). See also Curran, Jaffe, Hardy, Morgan, Selik & Dondero, *Epidemiology of HIV Infection and AIDS in the United States*, 239 SCIENCE 610 (1988) [hereinafter *Epidemiology*] (article reports 70,000 cases in 126 countries). Obviously, reporting facilities and definitions affect numbers. By July 1, 1988, the World Health Organization reported 100,410 cases from 138 countries. Mann & Chin, *AIDS: A Global Perspective*, 319 NEW ENG. J. MED. 302 (1988).

19. As of Monday, April 4, 1988, the 10 American cities with the highest incidence of AIDS were: New York (13,425), San Francisco (5,181), Los Angeles (4,558), Houston (1,967), District of Columbia (1,762), Newark (1,680), Miami (1,516), Chicago (1,416), Dallas (1,220), and Philadelphia (1,164). Wash. Post, Apr. 7, 1988, at A3, col. 2 (citing CDC statistics).

20. Fauci, *The Human Immunodeficiency Virus: Infectivity and Mechanisms of Pathogenesis*, 239 SCIENCE 617 (1988) (footnote omitted). See also *Coolfent Report: A PHS Plan for Prevention and Control of AIDS and the AIDS Virus*, 101 U.S. PUBLIC HEALTH SERVICE, PUB. HEALTH REP. 341, 342 (1986).

writes, AIDS "is like the day after Hiroshima—the world has changed and will never be the same again. The new virus will be a fact of life for our children's children; much can be done to moderate its force, but it cannot be made to disappear."²¹

The numbers cannot be controlled, nor will they go away. Indeed, even though the projected spread of AIDS into the broader heterosexual populations has not occurred to the extent originally projected, "in the New York City area where the virus has 'settled in,' the rates of seropositivity in men and women 18 to 25 years of age are nearly equal and approach 2 percent."²² Then there is the picture of Africa and dramatic proof that the disease is not confined to homosexual men. It is estimated that there are millions of infected individuals in Central Africa,²³ where the heterosexual nature of the transmission is far different from the United States; new countries are constantly being added to the list where infection is discovered.²⁴ The spread of AIDS in Africa demonstrates unequivocally that the disease is easily transmitted through vaginal intercourse, and is not merely a problem for the homosexual and drug user communities.²⁵

21. Osborn, *supra* note 15, at 445. See also Heyward & Curran, *The Epidemiology of AIDS in the U.S.*, 259 SCI. AM. 72 (1988) (describing various possibilities of chains of infection).

22. Osborn, *supra* note 15, at 447. The United States armed forces have already screened more than 300,000 volunteers for military service for the presence of the virus and found an infection rate of 1.5 per thousand nationally. See Burke, Brundage & Herbold, *Human Immunodeficiency Virus Infections Among Civilian Applicants for the United States Military Service, October 1985 to March 1986: Demographic Factors Associated with Seropositivity*, 317 NEW ENG. J. MED. 131 (1987). See also *Pentagon AIDS Testing Finds 5,890 Infected*, N.Y. Times, Feb. 7, 1988, at A28, col. 1 (two years after starting an extensive screening program for infection with the AIDS virus, the Defense Department has tested nearly four million people and has identified 5,890 who carry the deadly virus). The testing has cost \$43.1 million and is projected to cost \$25.5 more in the current fiscal year. *Id.*

23. Quinn, Mann, Curran & Piot, *AIDS in Africa: An Epidemiologic Paradigm*, 234 SCIENCE 955 (1986). The method of acquiring the disease differs among countries. "Whereas in Europe and in most of the Americas transmission of HIV-1 has occurred predominantly among homosexual men and intravenous drug abusers, in Africa a distinct epidemiologic pattern has emerged that indicates that HIV-1 infection is mainly heterosexually acquired." *Id.* See also Simonses, Cameron, Gakinya, Ndinya-Achalo, D'Costa, Keresira, Cheang, Ronald, Pilot & Plummer, *Human Immunodeficiency Virus Infection Among Men With Sexually Transmitted Diseases: Experience from a Center in Africa*, 319 NEW ENG. J. MED. 274 (1988); Piot, Plummer, Mhalu, Lamboray, Chin & Mann, *AIDS: An International Perspective*, 239 SCIENCE 573 (1988).

24. See Wash. Post, Apr. 19, 1988, at HE5, col. 3.

25. Rosenthal, *On My Mind: Doctor vs. Doctor*, N.Y. Times, Feb. 16, 1988, at A21, col. 4. Dr. Jonathan Mann, the American director of the AIDS program of the World Health Organization (WHO), reports that AIDS is a risk to the heterosexual population in the United States, in spite of the fact that few cases have been reported. *Id.* See also Okie, *Sexual Transmission of AIDS Unpredictable*, Wash. Post, Jan. 1, 1988, at A10, col. 2. The newspaper report cites the *Journal of the American Medical Association* as saying "[t]he low rate of transmission of the virus among couples in the study should not lead heterosexual adults to stop worrying

2. Deaths

According to the *New York Times*, AIDS is the leading cause of death among New York men 25 to 44 years old and New York women 25 to 34.²⁶ The *Times* also predicts a devastation among San Francisco's male homosexual population which will affect demographics and politics.²⁷ By the end of 1987, 56% or 27,909 persons were reported to have died of AIDS, including over 80% of those diagnosed before 1985.²⁸ According to Dr. Anthony S. Fauci, Director of the National Institute of Allergy and Infectious Diseases, "[t]he immune defect appears to be progressive and irreversible, with a high mortality rate that may well approach 100 percent over several years."²⁹ Thus, even though the government has increased support for research and new drugs are being tested,³⁰ there is still no cure for the disease and the estimates of those infected who will eventually die continue to rise.

3. Testing

Advanced testing procedures are affecting the numbers of persons shown to be infected with HIV.³¹ Such tests were not licensed by the Food and Drug Administration until 1985, when they were approved primarily as screening tests for blood and plasma donations.³² Since

about acquiring the AIDS virus from a sexual partner." *Id.* Factors such as drug use and prior venereal disease must also be taken into consideration. See Thompson, *Measuring the Spread of the AIDS Virus: Baltimore Inner-City Clinics Find Heterosexual Cases on the Rise*, Wash. Post, Feb. 2, 1988, at HE15, col. 1.

26. *Spread of AIDS Abating, But Deaths Will Still Soar*, N.Y. Times, Feb. 14, 1988, at A1, col. 4.

27. *Id.*

28. *Epidemiology*, *supra* note 18, at 610.

29. Fauci, *supra* note 20, at 617.

30. See Matthews & Bolognesi, *AIDS Vaccines*, 259 SCI. AM. 120 (1988); *Treatments and Vaccines: A Status Report*, Wash. Post, Jan. 19, 1988, at HE7, col. 1; *New Technique May Create Decoy to Halt Spread of AIDS*, N.Y. Times, Dec. 18, 1987, at A1, col. 5; *Testing of AIDS Vaccine Approved*, Wash. Post, Aug. 18, 1987, at A4, col. 1; see also Kaplan, Wofsy & Volberding, *Treatment of Patients With Acquired Immunodeficiency Syndrome and Associated Manifestations*, 257 J. A.M.A. 1367 (1987).

31. It is always important to note the distinction between HIV infection and the symptoms of AIDS itself. AIDS is a progression from earlier HIV infection and may be identified by any one of the following symptoms: unexplained fevers, night sweats, fatigue, weight loss, persistent diarrhea, chronic cough, shortness of breath, dark skin bumps usually starting on the feet or lower legs, swollen glands in the neck, groin, or under the arms, or an impaired mental condition. *Consultation: Taking the AIDS Test*, Wash. Post, June 23, 1987, at HE17, col. 1. See also *Wider AIDS Definition Proposed in Move to Expand U.S. Benefits*, N.Y. Times, May 1, 1987, at A1, col. 3 (dementia and emaciation was not included among the symptoms associated with AIDS until after Spring 1987).

32. Sperm and organ donations are also the subject of testing, but the procedure has not developed as well as with blood and plasma products. *Testing Donors of Organs, Tissues, and Semen for Antibody to Human T-lymphotropic Virus Type III/lymphadenopathy-associated Virus*, 34 CDC MORBIDITY & MORTALITY WEEKLY REP. 294 (1985). See also *Human Immunodeficiency Virus Infection Transmitted from an*

1985, HIV antibody tests have been used heavily by blood plasma and collection centers, counseling and testing centers, and by the military in screening applicants and active duty personnel.³³ In an effort to evaluate performances of these programs, the Centers for Disease Control Training and Laboratory Program Office (TLPO) sent enrollment forms to laboratories that participated in CDC's earlier proficiency training program. Through evaluation, CDC is seeking to: (1) build a database of information that describes the testing practices and the physical and technical characteristics of HIV testing laboratories, (2) evaluate the quality of HIV testing, (3) establish an information exchange network, (4) identify and define problems in HIV testing, and (5) improve and maintain the quality of HIV testing.³⁴

At present, the Public Health Service considers an individual to "have serologic evidence of HIV infection only after an enzyme immunoassay (EIA) screening test is repeatedly reactive³⁵ and another test such as Western blot (WB) or immunofluorescence assay has been performed to validate the results."³⁶ Validation is extremely important and will have significant human and legal consequences.³⁷

Presently, there are four favored tests³⁸ used to determine serologic evidence of HIV infection: enzyme immunoassay (EIA) (most commonly used), Western blot (WB), immunofluorescence assay, and Quan-

Organ Donor Screened for HIV Anti-body—North Carolina, 36 CDC MORBIDITY & MORTALITY WEEKLY REP. 306, 306-07 (1987) (organ donor declared brain dead two days after testing negative for the HIV antibody, and then found to have infected recipients of donated organs).

33. *Update: Serologic Testing for Antibody to Human Immunodeficiency Virus*, 36 CDC MORBIDITY & MORTALITY WEEKLY REP. 833, 833 (1988) [hereinafter *Serologic*]. For pertinent data on testing see *Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS*, 36 CDC MORBIDITY & MORTALITY WEEKLY REP. 509, 509-15 (1987). See also Mortimer, Parry & Mortimer, *Which Anti-HTLV-III/Lav Assays for Screening and Confirmatory Testing?* 2 LANCET 873, 873-77 (1987).

34. *Performance Evaluation Program: Testing for Human Immunodeficiency Virus Infection*, 36 CDC MORBIDITY & MORTALITY WEEKLY REP. 614, 614 (1987). *Serologic*, *supra* note 33, at 835 (stating that "[t]en of 19 laboratories bidding for contracts to perform WB tests for the Department of Defense failed the required proficiency panel on one or more occasions").

35. *Serologic*, *supra* note 33, at 833.

36. *Id.*

37. *Id.* The essential precaution is to validate the EIA test result with an independent supplemental test of high specificity conducted in a laboratory with high performance standards. But note that this procedure has the potential of cost, awareness, and time inhibitors; certainty and freedom from discrimination could belong to those who can afford it.

38. On May 26, 1988, *The Washington Post* reported on the polymerase chain reaction (PCR) test. This additional test, which increases the amount of DNA in a blood sample so that even small amounts of the virus can be identified, is a fifth test. Even though the test is not likely to replace conventional antibody tests for mass screening, it will be helpful in treatment of infection. *New Technique Helps in Detecting AIDS Virus*, Wash. Post, May 26, 1988, at A3, col. 1.

titative Bioassay. Quantitative Bioassay is a new test based on trans-activation. It has been developed for the detection and quantitation of the HIV-1.³⁹ The new test allows for detection of the time course of infection as well as the evaluation of anti-HIV agents. Above all, it is not influenced by other viruses and it is sensitive and relatively rapid.⁴⁰ While the EIA is used most frequently, the Quantitative Bioassay test presently offers the most promise in monitoring contagiousness, predicting progression of the disease, testing effectiveness of drugs and identifying the presence of HIV-1.

4. *New Threat*

In December 1987, the first victim of human immunodeficiency virus type 2 (HIV-2) in the United States was diagnosed.⁴¹ There is evidence that neurologic symptoms seem particularly associated with the HIV-2 infection. Instead of killing immune system cells as the HIV-1 infection does, the new strain kills through dementia and nervous system failure.⁴²

The presence of this new virus—and researchers are finding other strains of HIV-2—is a very significant factor as it jeopardizes any certainty presently existing in regard to testing.⁴³ Treatment and manner of transmission is also affected. Nonetheless, even though several well-documented cases of HIV-2 infection have been reported among Europeans and among West Africans residing in Europe, randomly selected testing among 8,503 blood donors in the United States failed to reveal HIV-2 infection. Reports indicate that HIV-2, though not prevalent in the United States, should be expected to emerge in isolated instances.⁴⁴

Newspapers and scientific journals report new threats associated with AIDS. Not too long ago, scientists thought that AIDS was like po-

39. Felber & Pavlakis, *A Quantitative Bioassay for HIV-1 Based on Trans-activation*, 239 SCIENCE 184, 184 (1988). See also *New Test Can Confirm AIDS, Other Infections*, Wash. Post, Jan. 15, 1988, at A5, col. 4; *New Method Reported to Detect AIDS Virus*, N.Y. Times, Jan. 9, 1988, A7, col. 5.

40. Felber & Pavlakis, *supra* note 39, at 186.

41. See *AIDS Due to HIV-2 Infection—New Jersey*, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 33, 33 (1988) [hereinafter *HIV-2 Infection*]. See also *U.S. Patient Found With Second Variety of AIDS Virus*, N.Y. Times, Jan. 28, 1988, at A4, col. 4; *First U.S. Case of Second Form of AIDS Reported*, Wash. Post, Jan. 28, 1988, at A9, col. 1.

42. See *An AIDS Strain Kills in Different Way*, Wash. Post, June 10, 1988, at A4, col. 4 ("Researchers have suspected for some time that there are major differences between those who have the common variety of AIDS, which kills the T cells in the immune system, and those whose symptoms are mainly in the brain and the rest of the nervous system.").

43. *Id.* HIV-2 is found chiefly in West Africa where there is little or no HIV-1 infection. *Id.* New strains of HIV-2 infection may be less virulent than earlier ones. *Id.*

44. *HIV-2 Infection*, *supra* note 41, at 34.

lio—only a fraction of those infected would eventually become sick. But a recent *Science* magazine study states that the average incubation period in homosexual men is 7.8 years—a figure similar to that found among infected transfusion recipients—and that chances of becoming ill increase significantly over time. Sometimes the incubation period can be as long as fifteen years.⁴⁵ Government sources now believe that all infected persons could become symptomatic if no treatment for AIDS can be found.⁴⁶ Research is discovering new threats and predicting new harmful results. Indeed, researchers at Los Alamos National Laboratory and Harvard University have created an AIDS “family tree.”⁴⁷

C. A Continually Changing Family

Despite a fear of AIDS, the American family continues to change.⁴⁸ Even though there seems to be a reversal of the federal domination of domestic relations through the process of constitutionalization,⁴⁹ the statistics do not indicate any reversal of societal trends associated with marriage, cohabitation, illegitimacy, or the effect of poverty.⁵⁰ Fear of

45. *AIDS Virus Likely Fatal to All Infected*, Wash. Post, June 3, 1988, at A1, col. 5.

46. *Id.* at A14, col. 1. The report uses data from a sample of men who enrolled at San Francisco City Clinic between 1978 and 1980 for studies of hepatitis B. This is the blood supply—from 6,709 homosexual and bisexual men—upon which predictions are made of the spread of the disease.

47. Wash. Post, June 13, 1988, at A3, col. 6. In analyzing the family tree of the AIDS viruses, the *Washington Post* concludes that “the monkey versions of the virus did not give rise to the human versions.” *Id.* Rather both the monkey version and the human version split from an earlier virus 40 or 80 years ago and, after the split, “one branch of the family became the HIV-1 The other branch split into fairly closely related viruses: HIV-2, which infects and causes diseases in humans, and SIV (simian immunodeficiency virus) strains, which infect monkeys.” *Id.* See also Essex & Kanki, *The Origins of the AIDS Virus*, 259 SCI. AM. 64 (1988) (AIDS virus has relatives in men as well as other primates).

48. See R. O'BRIEN, AIDS AND THE LAW 89-90 (1987). For a further discussion of changes in the American family, see *supra* notes 1-7 and accompanying text.

49. In 1858, the Supreme Court stated: “We disclaim altogether any jurisdiction in the courts of the United States upon the subject of divorce, or for the allowance of alimony, either as an original proceeding in chancery or as an incident to divorce a vinculo, or to one from bed and board.” *Barber v. Barber*, 62 U.S. (21 How.) 582, 584 (1858). Despite this earlier pronouncement, the federal courts have always found ways to protect individual freedoms in the domestic relations context. However, with recent Court appointments by President Reagan, there is reason to think that the Court will return to the dicta of *Barber* and adopt a presumptive domestic relations exception. See *Santosky v. Kramer*, 455 U.S. 745, 771 (1982) (Rehnquist, J., dissenting) (“[T]he Court has scrupulously refrained from interfering with state answers to domestic relations questions.”); see also *Thompson v. Thompson*, 108 S. Ct. 513, 520 (1988) (Court affirms ruling that child custody litigants caught between two state courts unwilling to agree on appropriate locus for custody determination may not turn to federal courts for assistance in settling dispute).

50. United States Census Bureau statistics continue to show an increase in couples of the opposite sex cohabiting without marriage: 439,000 in 1960;

AIDS may well limit possibilities and risk for a few, but the majority of Americans have not demonstrated any major shift in family structure. Nevertheless, it is becoming clear that the most pronounced effect of AIDS upon the changing American family will be at the level where poverty, drugs, or prostitution interact with family structure. Inasmuch as cohabitation and single parenting⁵¹ exist within the homosexual community, AIDS will interact proportionally. Thus, since AIDS is most manifest in the male homosexual community and that community has established its own identification as family,⁵² AIDS will continue to have a substantial impact on that community.⁵³

But the most significant interaction between AIDS and the changing American family structure is in connection with poverty, drugs, and prostitution. Moreover, because many minorities are inordinately affected by these three high-risk associations, it is more than reasonable to assume that AIDS will have a far greater impact upon minority family structure than it will upon non-minority family structure. This conclusion, added to the well-documented evidence that minority family structure has always been under strain, should demand increased assistance for minority families.⁵⁴ Although AIDS is not racially motivated or activated, the disproportionate number of minorities living in communities where poverty, drugs, and prostitution are commonplace, leads to an

523,000 in 1970; 1.5 million in 1980; 2.2 million in 1986. U.S. BUREAU OF CENSUS, U.S. DEP'T OF COMM., CURRENT POPULATION REPORTS, HOUSEHOLDS, FAMILIES, MARITAL STATUS AND LIVING ARRANGEMENTS 2 (1986). The earlier figures are partly based on projections and assumptions. Poverty has been identified as perhaps the principal risk to families. See ADVISORY COMM'N ON CHILD DEVELOPMENT, TOWARD A NATIONAL POLICY FOR CHILDREN AND FAMILIES 14-39 (1976). See also A. SHYNE & A. SCHROEDER, NATIONAL STUDY OF SOCIAL SERVICES TO CHILDREN AND THEIR FAMILIES 1-8 (1978). Sociologist Jonathan Kozol observes that "[t]he rate of child poverty in 1986 was one-third higher than ten years before. The Children's Defense Fund states that child poverty, which has increased 50 percent since 1969, now affects 'nearly one out of every three children under the age of six.'" J. KOZOL, RACHEL AND HER CHILDREN 81 (1988).

51. Senator Moynihan reports:

In 1984 single-parent families with children accounted for more than one quarter (26 percent) of all family groups (white, black, Hispanic, et al.) compared with 22 percent in 1980 and only 13 percent in 1970. Since 1970 the number of single-parent families had increased 124 percent, while the number of all families with children increased only 12 percent and the number of married-couple families with children actually declined 4 percent.

D. MOYNIHAN, FAMILY AND NATION 146 (1985).

52. See F. FITZGERALD, CITIES ON A HILL 12 (1986) (homosexuals living in San Francisco strive to challenge traditional nuclear family).

53. There is a substantial amount of literature being written concerning the death of lovers and friends in the homosexual community. See generally R. SHILTS, *supra* note 4. See also C. DAVIS, VALLEY OF THE SHADOW (1988); P. REED, FACING IT (1984).

54. See D. MOYNIHAN, *supra* note 51, at 53-57 (notes problems of minority children returning "home to a family devoid of basic . . . [necessities] for . . . discipline, growth, and development").

increased likelihood that AIDS will impact minority families more severely. Quite simply, poverty, drugs and prostitution could be to ghetto communities what gay bath houses were to the homosexual community: facilitators for the virus.

In addition to private and government surveillance of HIV infection in ghetto communities, education within the community, and awareness of past patterns of discrimination, are immediate responsibilities within the changing American family. It is especially true today that "[r]epair of the black family is central to any serious strategy to improve the black condition."⁵⁵ Indeed, AIDS continues to be a civil rights issue in both the homosexual and poor minority communities.

It is almost impossible to predict what effect AIDS will have upon the majority of American families. "How persons and couples fit within the definition of family, the perspective of the legislature where the person or couple resides, and the nature of the activity itself will all be important as AIDS has an impact on families—and as states seek to regulate health and safety."⁵⁶ Unfortunately, as Professor Judith Areen notes: "[i]dentifying the proper balance between individuals and family is complicated by the fact that the social consensus as to what constitutes acceptable family life is weaker than ever."⁵⁷ We now know, however, that HIV infection has penetrated American family life; affecting some groups more than others. Perhaps the presence of the virus will reverse the possibilities of the family definition and prompt a return to reduced risk groupings, but the present statistics do not indicate such a trend. What is certain is that any discussion of AIDS must include an examination of its effect upon the *changing* American family. Indeed, it is possible to conclude that, because AIDS affects sex, an essential ingredient of family life, AIDS will have an immense effect upon the character, formation, and quality of family life long after a cure has been found. Sexual activity within the family will change even though the form the family takes will seem impervious to change.

55. *Id.* at 53. Senator Moynihan cites Eleanor Holmes Norton, the former director of the Equal Employment Opportunity Commission. Ms. Norton insisted on the family as a civil rights issue. *Id.* Also, the National Association for the Advancement of Colored People (NAACP) issued a statement in 1983 saying that, "finding ways to end the precipitous slide of the black family is one of the most important items on the civil rights agenda today." *Id.* at 55.

56. R. O'BRIEN, *supra* note 48, at 90. There will most certainly be increased opposition to state regulation of intimate relations. See *Premarital AIDS Testing Annoying Many in Illinois*, Wash. Post, July 30, 1988, at A9, col. 1. Since adoption of premarital testing in Illinois, 10 of more than 75,000 marriage license applicants have tested positive for the virus. *Id.*

57. J. AREEN, *FAMILY LAW* at xxi (2d ed. 1985).

II. ECONOMIC ISSUES: FAMILIES IN GENERAL

A. *Single Parents*

The most insidious feature of AIDS intrusion into the minority population is the fact that no one can conclude why the disease's appetite in that community is so disproportionate.⁵⁸ Whatever the reason, this disproportionate infection among minorities must be taken into consideration in apprising the effect of AIDS upon families in general, and single parent families in particular. Indeed, while America may be preparing for a sudden and catastrophic rise in the number of heterosexually transmitted cases of AIDS,⁵⁹ the clear and immediate danger seems to lie with minorities. That danger is infecting all age groups within the minority population—both children and adults.

As AIDS affects different ages of the population, so does it affect family law structures such as child care, pediatrics, education, right to marry, right to procreate, right to personal sexual relations, right to privacy, right to custody of children,⁶⁰ and right to the dignity and comfort of Medicaid and Medicare. As of late 1987, the age at diagnosis of having AIDS by racial/ethnic groups was as follows:⁶¹

Age Group	White		Black		Hispanic	
	Number	(%)	Number	(%)	Number	(%)
Under 5	87	(0)	285	(3)	124	(2)
5 -12	31	(0)	26	(0)	14	(0)
13-19	67	(0)	62	(1)	32	(1)
20-29	4771	(19)	2509	(25)	1302	(23)
30-39	11542	(46)	4827	(48)	2726	(47)
40-49	5694	(23)	1703	(17)	1109	(19)
Over 49	2898	(12)	718	(7)	454	(8)
TOTAL	25090	(61)	10130	(24)	5761	(14)

Examining all of the present data, the Centers for Disease Control estimates that "the prevalence of HIV infection first becomes apprecia-

58. *Human Immunodeficiency*, *supra* note 12, at 11.

59. At present, the projected increase in heterosexually transmitted cases of AIDS has not become a reality without the added intervention of tainted blood or IV drug usage. Nonetheless, as stated earlier, the extent of the disease in Africa demands caution. The testing among civilian applicants for military service from October 1985 through March 1986, "suggests that female infections have become increasingly common in recent years." Redfield & Burke, *Shadow on the Land: The Epidemiology of HIV Infection*, 1 *VIRAL IMMUNOLOGY* 75 (1987).

60. See R. O'BRIEN, *supra* note 48, at 89 (describing how these rights are essential characteristics of American family). Testing for HIV among infants is becoming routine. See *U.S. to Test Third of New Babies for AIDS*, Wash. Post, Aug. 23, 1988, at A1, col. 1 (anonymous testing of infants); *D.C. to Test Newborns, Clinic Patients for AIDS*, Wash. Post, Aug. 18, 1988, at D5, col. 4.

61. See CDC AIDS WEEKLY SURVEILLANCE REP., Aug. 31, 1987, at 1-5.

ble in the mid to late teens; increasing rapidly into the late 20's and early 30's, where it peaks; and then declines in the 40's and 50's."⁶² Remembering that this HIV infection is not associated with symptoms, but rather with the ability to transmit the virus, this is the group which harbors the greatest risk to marriage, children, heterosexual contact, and sexual promiscuity. When we further examine the data, we find that these HIV infected persons are extremely likely not only to be single parents, but also minority, poor and uninsurable. For instance, consider the statistics published by the Children's Defense Fund:

Teens who by age fourteen or fifteen have very weak basic skills are five times more likely to become mothers before the age of sixteen than those with average basic skills.

Young women who by age seventeen or eighteen have very weak basic skills are two and a half times more likely to be mothers before their twentieth birthday than those with average basic skills.

Young men who by age seventeen or eighteen have very weak skills are three times more likely to become fathers before the age twenty than those with average basic skills.⁶³

Many of these young men and women are poor. In 1985, 30.2 percent of single and two-parent families with children and with a head of household younger than twenty-five were below the poverty line.⁶⁴ When the Congressional Budget Office found in 1983 that the poverty rate reached an eighteen year high, a dramatic rise in female-headed [single parent] households was the primary cause.⁶⁵ Along with this grim statistic, the number of children below the poverty line also increased dramatically.⁶⁶ Indeed, more than 20% of our children live in poverty; between 34 and 45 percent of our preschoolers are not fully immunized;⁶⁷ more than 20% of the population in shelters for the

62. See *Human Immunodeficiency*, *supra* note 12, at 10.

63. CHILDREN'S DEFENSE FUND, A CHILDREN'S DEFENSE BUDGET at xiii (1987).

64. *Id.* at xxii.

65. D. MOYNIHAN, *supra* note 51, at 95.

66. *Id.* at 95-96.

67. Immunization has particular significance in relationship to AIDS. In April 1988, the CDC wrote:

During 1986 and 1987, large measles outbreaks occurred in urban areas of the United States among preschool-age children with low immunization levels. These areas (New York, Jersey City, and Miami) also have high incidence rates of pediatric acquired immunodeficiency syndrome. Since HIV-infected children may live in areas where measles virus circulates because of low preschool measles immunization levels, they may be at higher risk of exposure to measles than other children in the United States.

Measles in HIV-Infected Children, United States, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 185 (1988).

homeless are children.⁶⁸

Unless there is a dramatic change in societal perception—perhaps brought on by the AIDS crisis—the future, in the words of Senator Moynihan, looks to be much like the recent past. A recent study by the Greater Washington Research Center reported that “[one] third of the people in poverty in the District [of Columbia] are children, four out of five are black, and an even more disproportionate number are Hispanic.”⁶⁹ In light of all presently available data, poverty seems destined to be the fate of single parents,⁷⁰ a disproportionate number of minorities,⁷¹ and of course children. It seems, looking into the future, that by the year 2000, the poverty population will consist solely of women and their children.⁷²

In light of growing poverty among children and young families, the economic consequences of HIV infection, subsequent illness and eventual death will certainly be catastrophic.⁷³ The human loss in suffering and death will be cataclysmic, most certainly in urban areas. But the greatest disaster would arise from our failure to recognize the present association of AIDS with at-risk minorities, the incentive given to HIV infection through association with poverty, and the high risk associated

68. CHILDREN'S DEFENSE FUND, CDF'S LEGISLATIVE AGENDA FOR THE 100TH CONGRESS 1 (1988). A study conducted by Covenant House, the private social welfare agency in Manhattan, and the New York State Department of Health concluded that about 1,500 of the city's estimated 20,000 homeless youth are HIV positive. *New York City Street Youth: Living in the Shadow of AIDS*, N.Y. Times, Nov. 14, 1988, at A1, col. 1.

69. See *One Third of the District's Poor Are Children*, Wash. Post, Apr. 6, 1988, at A1, col. 1. The study notes that in the District of Columbia, 40,000 children live in households that receive public assistance and are generally headed by women. The study's authors also said that their results understate the size of the city's poor population because the survey did not include the homeless population. *Id.*

70. Children born out of wedlock is the predominant reason for single parenthood. Senator Moynihan notes that “[t]here are but ten states in the Union where out-of-wedlock births to women under age twenty comprise less than 40 percent of all births; in half the states, this percentage is greater than half.” D. MOYNIHAN, *supra* note 51, at 168.

71. Senator Moynihan notes that “the turn of the century will see 70[%] of all black families headed by single women” Such households are concentrated in central cities, where in 1983 the poverty rate for all school-age children was 30%. *Id.* at 97.

72. *Id.* at 51 (noting estimate of the 1980 report to the President by the National Advisory Council on Economic Opportunity).

73. See R. O'BRIEN, *supra* note 48, at 90-92. In May 1988, the Health and Human Services Department reported that the number of patients with AIDS rose 270% between 1984 and 1986. Wash. Post, May 27, 1988, at A8, col. 1 (stating generally that between 1984 and 1986 AIDS patients had more than 1 million days in hospital, with average stay of 16 days each time admitted). In December 1988, the National Center for Health Statistics reported that, “[f]or the first time in this century, the life expectancy of blacks in the United States has declined in two successive years while that for whites has continued to increase.” *Blacks' Life Expectancy Drops*, Wash. Post, Dec. 15, 1988, A1, col. 1.

with single parents, poverty, minorities and children. In order to prevent these economic and human consequences, present research, education and assistance must be directed more toward targeted groups.⁷⁴ This is the most essential—and most recent—lesson to be learned concerning single parents.

B. *Employment Discrimination*

An individual's ability to secure gainful employment is critical to that person's right to make choices and maintain a sense of personal dignity. Employment quite simply captures the gist of the constitutional pursuit of happiness. As money and employment are related to productivity and responsibility, the family is affected in a direct and essential manner. Thus, it is not surprising that all fifty states have at least some form of handicap-employment legislation. A review of that legislation would indicate that states prefer to protect the employment of the citizen over the suspicions of the employer.⁷⁵ But what of the employer and the concessions that he or she must make? And what of the fellow employees?⁷⁶ And what of health and disability insurers who have provided group coverage with minimum investigation?⁷⁷

Although traditionally litigation was the primary vehicle for attacking employment discrimination, there is not much activity in the courts today, perhaps because of recent legislation initiatives, judicial deci-

74. Approximately 107 million English-language versions of a brochure, *Understanding AIDS*, were distributed to every home and residential post office box between May 26 and June 30, 1988. See *Understanding AIDS: An Information Brochure Being Mailed to All U.S. Households*, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 261, 261-69 (1988) [hereinafter *Understanding AIDS*]. See also Cleary, *Education and the Prevention of AIDS*, 16 LAW MED. & HEALTH CARE 267 (1988).

75. See Goff, *AIDS: The Legal Issues*, 2 WASH. LAW. 36, 36-38 (1988); Lyons, *The Department of Justice: Dealing with A Constellation of Problems*, 7 DEL. LAW. 71 (1988); Steinhilber, *AIDS and Employment: Legal and Policy Considerations*, 35 FED. B. NEWS 377 (1988).

76. In *Pawlish v. Barry*, 126 Wis. 2d 162, 376 N.W.2d 368 (1985), where an employer sought to remove an employee who expressed opinions that were hostile to persons with AIDS, the court allowed the employee to be dismissed even though the employee said his opinions were protected by the first amendment. *Id.* at 167, 376 N.W.2d at 371. The court reasoned that the employee's position was totally dependent upon "the pleasure" of the employer and the employee had expressed an opinion that was opposed to the non-discrimination policy of the employer. *Id.* But see *Nurse Wins Comp Claim Over Fear of AIDS*, AIDS Policy & Law (BNA), at 2-3 (Feb. 25, 1987) (while settling \$5,000 case brought by nurse at San Francisco General Hospital, City of San Francisco established precedent that nurse suffered temporary workers compensation disability from stress resulting from perception that virus could be transmitted in workplace).

77. See generally Blaine, *AIDS: Regulatory Issues for Life and Health Insurers*, 1986 A.B.A. SEC. TORT INS. PRAC. REP. 1, 18-22. The author writes of the interaction among state statutes, group insurance plans and underwriting standards that determine eligibility for coverage, and the AIDS epidemic.

sions, or a developing pattern of more subtle forms of discrimination.⁷⁸ American law has always presumed that the "employment relationship in the private sector is 'at will' unless the employer's discretion to terminate the relationship has been abridged by contract, statute, or, in some jurisdictions, public policy."⁷⁹ An examination of the relevant statutes or of the judicial and administrative opinions in this area will show that the "will" of the employer is often circumscribed when discrimination is present and that discrimination is against a person or group thought worthy of protection. Today, as AIDS progresses through the population, an increasing number of states, counties and cities are including AIDS as a specific part of anti-discrimination statutes and not relying on general phrases such as "handicap" or "disability" to trigger the statute.⁸⁰ For instance, a Los Angeles ordinance prohibits discrimination against persons with AIDS and anyone else discriminated against because of the fear of AIDS in conjunction with employment, rental housing, business establishments, city facilities and educational institutions.⁸¹ Upon proof of violation, the ordinance allows for injunctive re-

78. Ken Labowitz, an attorney specializing in discrimination cases, characterizes the present discrimination cases involving persons with AIDS as presently *lacking* the subtlety of other forms of discrimination:

We haven't reached the level of sophistication, as we have in racial and sex discrimination cases, where people are circumspect about what they do. It is unlikely that an employer will say "I'm firing you because you are black," or pregnant, or female. You have to prove it by indirect means. But here, employers come right out and say: "I'm firing you because you have AIDS."

When Employers Fire Out of Fear, AIDS LAW REP., Oct. 1987, at 1.

79. Leonard, *Employment Discrimination Against Persons With AIDS*, 19 CLEARINGHOUSE REV. 1292, 1296 (1986). No doubt employers are convinced that they are acting in the best interest of the other employees, clients and themselves when they dismiss an individual employee because he or she has been diagnosed with AIDS. The employer feels justified because of a sense of public policy. This justification must stem in part from the acquired nature of AIDS and the past association with non-protected groups, that is, homosexuals and drug users. See *AIDS Discrimination Issue Mushrooming*, Wash. Post, Nov. 24, 1986, at A1, col. 3 (noting AIDS has become an excuse for discriminating against gay people).

80. A number of states, counties and cities have made AIDS a specific part of anti-discrimination legislation. See generally *A Survey of Legal Issues Related to Acquired Immune Deficiency Syndrome (AIDS)*, Op. Off. Legal Counsel (1987) [hereinafter *Survey*].

81. See *AIDS: A Litigation Challenge Searching for Solutions*, 1987 A.B.A. SEC. LIT. REP. 36 (citing Los Angeles Ordinance). There are specific exceptions to the statute's prohibitions for blood banks, surrogate mother facilities, or other establishments engaged in the exchange of products containing elements of blood or sperm. Also exempted are religious organizations and conduct necessary to protect the health or safety of the population, as long as the latter can prove discrimination is a necessary result of a necessary course of conduct and that no less discriminatory means of protection exists. See generally Note, *Educating Through the Law: The Los Angeles AIDS Discrimination Ordinance*, 33 UCLA L. REV. 1410 (1986).

lief, actual and punitive damages, and attorneys' fees.⁸² Los Angeles and other California cities were the first to pass such AIDS specific ordinances. Other cities will undoubtedly follow that lead.⁸³ But, as with much of the legal apparatus surrounding AIDS, the laws, judicial decisions, and public policies are diverse and often vacuous in protection. It is not surprising that groups have called upon the federal government to provide relief.⁸⁴ Accordingly, there have been many attempts to pass federal AIDS statutes.⁸⁵ Almost in tandem, the states have been voracious in the introduction of comparable legislation.⁸⁶ There is no doubt that both federal and state legislative enactments will continue in response to the disease, with one of the few achievements being the \$1.5 billion program to fund AIDS testing, research and education.⁸⁷

The courts have also played a role in protecting employees with AIDS. However, the most cited case, *Arline v. School Board*,⁸⁸ only incidentally relates to AIDS. *Arline* involved a school teacher who was fired from her job solely because of her susceptibility to tuberculosis. She alleged that her dismissal violated section 504 of the 1973 Federal Rehabilitation Act which prohibits discrimination on the basis of handicap against any "otherwise qualified" handicapped individual. The Supreme Court decided only the issue of whether "a person afflicted with tuberculosis, a contagious disease, may be considered a 'handicapped individual' within the meaning of section 504 of the Act, and, if

82. One of the first suits under the ordinance involved a funeral home, sued because it refused to embalm a person because of fear of contracting the AIDS virus. See *Mortuary Hit With \$10 million AIDS Discrimination Suit*, L.A. Times, Oct. 2, 1985, at B1, col. 1. Another funeral home case in New York City provided the factual basis for a ruling that the New York City Commission on Human Rights may prosecute AIDS related discrimination cases under a city ordinance that prohibits discrimination against handicapped persons. See *Dimiceli & Sons v. N.Y.C. Comm'n on Human Rights*, No. 19527/86, slip op. (N.Y. Sup. Ct. Jan. 9, 1987).

83. Austin, Texas was the first city outside of California to pass an AIDS-specific anti-discrimination ordinance banning discrimination in employment, real estate or housing transactions, business establishments, and city facilities. See *AIDS Policy & Law* (BNA), at 1 (Dec. 31, 1986). Other cities and states will continue this trend as long as the disease remains one that cannot be acquired through casual contact.

84. REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 123 (1988) (federal anti-discrimination legislation which prohibits discrimination against persons with disabilities including AIDS, should be enacted).

85. *Id.*

86. For a summary of the state statutes see INTERGOVERNMENTAL HEALTH POLICY PROJECT, HIV-RELATED LEGISLATION 1986-1987 (1988) (available at George Washington Univ., Wash. D.C.) [hereinafter INTERGOVERNMENTAL HEALTH]. For the most recent developments, see INTERGOVERNMENTAL HEALTH POLICY PROJECT, STATE AIDS REPORTS (available at George Washington Univ., Wash. D.C.) [hereinafter STATE AIDS REPORTS].

87. INTERGOVERNMENTAL HEALTH, *supra* note 86, at 1.

88. 480 U.S. 273 (1987).

so, whether such an individual is 'otherwise qualified' to teach elementary school."⁸⁹ In addition to narrowly defining the scope of its holding, the remainder of the Court's opinion offers no enhancement. Consequently there are a number of issues still unresolved by *Arline*.

For instance: Were the District Court in *Arline* and the 1986 Justice Department memorandum correct in finding that Congress did not intend⁹⁰ to include infectious diseases within the section 504 definition of handicapped person?⁹¹ If so, would legislative action by Congress have addressed the issue?⁹² Would that legislative action specifically refer to

89. *Id.* at 275. The Supreme Court held that to answer if she is otherwise qualified, "the District Court will need to conduct an individualized inquiry and make appropriate findings of fact." *Id.* at 287. This inquiry was ordered in reference to *Arline* in accordance with guidelines the Court established:

based on reasonable medical judgments given the state of medical knowledge, (a) the nature of the risk (how the disease is transmitted about), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Id. at 288 (citations omitted). Once the findings are obtained, the court must evaluate if the employer can "reasonably accommodate" the employee. *Id.* See also *Alexander v. Choate*, 469 U.S. 287, 299-301 & 299 n.19 (1985); *Southeastern Community College v. Davis*, 442 U.S. 397, 410-13 (1979); *Strathie v. Department of Transp.*, 716 F.2d 227, 231 (3d Cir. 1983). See generally Note, *Accommodating the Handicapped: Rehabilitating Section 504 after Southeastern*, 80 COLUM. L. REV. 171, 178-79 (1980) (regulations "impose a greater obligation on post-secondary educational institutions than upon employers").

90. Chief Justice Rehnquist and Justice Scalia dissented in *Arline*. Their opinion is based on the understanding that when Congress provides a grant of federal funds, "it must do so unambiguously." *Arline*, 480 U.S. at 289 (Rehnquist, C.J., dissenting). Congress did not unambiguously state that the Act was to regulate discrimination on the basis of contagiousness. *Id.* at 291 (Rehnquist, C.J., dissenting). Therefore, the dissenters argued that "[a]ny interpretation of § 504 must . . . be responsive to two powerful but countervailing considerations—the need to give effect to the statutory objectives and the desire to keep § 504 within manageable bounds." *Id.* at 293 (Rehnquist, C.J., dissenting) (quoting *Alexander v. Choate*, 469 U.S. 287, 299 (1985)).

91. It can be argued that a person with AIDS is less contagious than a person with tuberculosis. The facts show that Gene Arline was hospitalized with tuberculosis in 1957, but the disease went into remission for the next 20 years. *Id.* at 276. It was not until 1977 that a culture revealed that the disease was again active in her system. *Id.* She was eventually dismissed at the end of the 1978-79 school year "not because she had done anything wrong," but because of the 'continued reoccurrence [sic] of tuberculosis.' *Id.* (quoting brief for appellant at 49-52). It should be noted that Arline was hired as a school teacher in 1966, nine years after the disease was diagnosed in 1957. *Id.* Comparisons can be made with AIDS and other diseases, but the non-casual nature of acquiring AIDS should eliminate the rational fear associated with contagion.

92. See Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, § 9, 102 Stat. 28, 31-32 (1988). The amended Act provides:

For the purposes of sections 503 and 504, as such sections relate to employment, such term does not include an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other

AIDS in the context of contagious diseases?⁹³ Also, if the legislative action specifically refers to AIDS, would the presence of HIV infection *alone* be sufficient to constitute a handicap, or would one have to have a symptom of the disease to qualify as a handicapped person?⁹⁴ Could Congress remedy this with a specific reference to HIV infection and the Rehabilitation Act's inclusion of the *perception of a handicap on others* as a singular factor?⁹⁵ Could the courts also interpret the present statute to do the same, making it easier for HIV infection without symptoms to be included in the definition of handicap?⁹⁶

individuals *or who*, by reason of the currently contagious disease or infection, *is unable* to perform the duties of the job.

Id. (emphasis added).

93. The majority opinion in *Arline* mentions AIDS only in a footnote to distinguish AIDS from tuberculosis. Justice Brennan writes: "This case [*Arline*] does not present, and we therefore do not reach, the questions whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act." *Arline*, 480 U.S. at 282 n.7.

94. A Memorandum for the U.S. Department of Justice takes the position that, "[a] person is not considered to have AIDS merely because tests show him to be generating antibodies to the AIDS virus." Memorandum from Douglas W. Kmiec, Assistant Attorney General, to Author B. Culvahouse, Jr., Counsel to the President, at 7 (Sept. 27, 1988) (discussing application of the Rehabilitation Act to HIV-infected individuals). Also, "a person is not considered to have AIDS if he is seropositive and also displays a number of symptoms characteristic of the disease." *Id.* at 8. Rather, "an essential element of the definition of AIDS used for reporting purposes by the Centers for Disease Control ("CDC") is affliction with one or more of the opportunistic diseases that take advantage of the patient's suppressed immune system." *Id.* Thus, AIDS could be defined as including dementia, emaciation, fatigue or any other physical or mental impairment defined by the Secretary of the Department of Health, Education, and Welfare in 1977. *Id.* Other jurisdictions take the position that seropositivity alone is sufficient to constitute the disease for purposes of protection. *See, e.g.*, *Salt Lake City Corp. v. Confer*, 674 P.2d 632, 635-36 (Utah 1983) (adopting federal definition of Rehabilitation Act); *District 27 Community School Bd. v. Board of Educ.*, 130 Misc. 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986) (because AIDS destroys certain lymphocytes, person with AIDS is handicapped).

95. *See* Rehabilitation Services Administration Act, 29 U.S.C. § 706(7)(B) (Supp. 1988) (providing that person can qualify as handicapped if he actually suffers from disabling impairment, has recovered from previous impairment, was misclassified as having such a condition, or is regarded as having such a condition whether or not he does so in fact). *But see* *de la Torres v. Bolger*, 781 F.2d 1134, 1138 (5th Cir. 1986) (left-handedness not an impairment); *Tudyman v. United Airlines*, 608 F. Supp. 739, 745-46 (C.D. Cal. 1984) (where condition voluntary, no impairment normally present); *Stevens v. Stubbs*, 576 F. Supp. 1409, 1414 (N.D. Ga. 1983) (transitory illness resulting in no lasting effects not impairment). The position of the dissenting Justices in *Arline* is that the Act does not allow for consideration of the reaction of others unless that reaction is considered together with the effect of the condition on the claimant. *Arline*, 480 U.S. at 292 (Rehnquist, C.J., dissenting).

96. Since HIV infection alone does not have any physical or mental effects, the issue becomes where to place the limits upon the Rehabilitation Act's protection. It can be argued that as long as AIDS precipitates such fear in others,

Furthermore, even if the Supreme Court's decision in *Arline* allows for a contagious disease to be included under the protection of the Rehabilitation Act, what effect does that have upon state statutes and ordinances?⁹⁷ Some argue that the situation now is similar to sexual discrimination and pregnancy, which prompted passage of the federal Pregnancy Discrimination Act in 1978. States, of course, can do whatever they please with their own laws.⁹⁸ All would admit that the different state statutes have different definitions, but the state's interest in providing employment and benefits to all persons is similar to that in the federal Rehabilitation Act. Therefore, it is reasonable to expect that the state courts will respond similarly, or if faced with different statutory wording, suggest that the state legislature amend the statute to provide protection and clarification.

Moreover, even if the person with AIDS (infected with the virus or presently demonstrating symptoms) is treated as handicapped within the meaning of the statute, additional practical problems remain. For example, how does an employer decide if the employee is "otherwise qualified" to perform the job and what constitutes "reasonable accommodation" by the employer?⁹⁹ If the person is a potential em-

HIV infection alone should be included within the definition of handicap because of the effect that the infection has on others. But does this extend the coverage too far? The *Arline* Court observes that "Congress was as concerned about the effect of an impairment on others as it was about its effect on the individual." *Arline*, 480 U.S. at 282. To apply to mere HIV infection, the definition of "physical or mental impairment" would need to be expanded beyond cosmetic disfigurement to include the HIV in tiny macrophages, white blood cells that are present everywhere in the body. See *The Evolving Biology of AIDS: Scavenger Cell Looms Large*, N.Y. Times, June 7, 1988, at C9, col. 1. Dicta in *Arline* leads one to believe that the courts are willing to expand the definition of physical or mental impairment to lessen discrimination. *Arline*, 480 U.S. 284 n.10 (arguing that primary goal of Act is to increase employment of handicapped). See also *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624, 632, 633 n.13 (1984).

97. In responding to the dissent, the majority in *Arline* opines that the inclusion of contagious diseases will assist the states in monitoring infectious diseases. *Arline*, 480 U.S. at 286 n.15. The Court notes that *amicus curiae* briefs were filed on behalf of Ms. Arline by several states, all of which argued that inclusion of communicable diseases within the ambit of the Act does not reorder the priorities of state regulatory agencies and would not alter the balance between state and federal authority. *Id.*

98. The United States Supreme Court had ruled in *General Electric Corp. v. Gilbert*, 429 U.S. 125 (1976), that the exclusion of pregnancy related disabilities from disability plan coverage was not discrimination in violation of Title VII of the Civil Rights Act of 1964. Almost immediately, the New York Court of Appeals held that such pregnancy related actions were discriminatory according to New York State Law. *Brooklyn Union Gas Co. v. New York State Human Rights Appeal Bd.*, 41 N.Y.2d 84, 359 N.E.2d 393, 390 N.Y.S.2d 884 (1976).

99. Because many persons with AIDS are living longer, often with disabilities requiring extensive medical out-patient care, these issues become more pervasive. Past cases provide a context. See, e.g., *Southeastern Community College v. Davis*, 442 U.S. 397 (1979) (otherwise qualified handicapped person is one who meets all of the program's requirements in spite of handicap); *Bento v. I.T.O. Corp.*, 599 F. Supp. 731 (D.R.I. 1984) (man with history of heart disease

ployee can an employer refuse to hire him or her because the employer simply does not want to spend the time or money on an employee who will become sick or die?¹⁰⁰ Moreover, is the possibility that all—or a substantial number—of the other employees will refuse to work with the person a sufficient reason to refuse to hire or to fire?¹⁰¹ Lastly, does an employer have the right to access health records and other medical information concerning the employee and to force an applicant or an employee to be tested?¹⁰² There are few definitive answers to any of these

not otherwise qualified when he sought job as longshoreman); *Treadwell v. Alexander*, 27 Fair Empl. Prac. Cas. (BNA) 543 (S.D. Ga. 1981) (individual with pacemaker not otherwise qualified to be park technician because job involved moderately arduous outdoor activity).

100. See *Mantolette v. Bolger*, 767 F.2d 1416 (9th Cir. 1985) (epileptic applied for job as machine operator and hired); *E.E. Black Ltd. v. Marshall*, 497 F. Supp. 1088 (D. Haw. 1980); *Sterling Transit Co. v. California Fair Employment Practice Comm'n*, 121 Cal. App. 3d 791, 175 Cal. Rptr. 548 (1981); *Baltimore & Ohio R.R. v. Bowen*, 60 Md. App. 299, 482 A.2d 921 (1984) (employer could not refuse to hire because of a fear that exertion associated with the job might dislodge a bullet lodged in the spine of the employee and result in spinal cord damage and possible paralysis); *Chrysler Outboard Corp. v. Wisconsin Dep't of Indus., Labor & Human Relations*, 14 Fair Empl. Prac. Cas. (BNA) 344 (Wis. Cir. Ct. 1976) (claim that individual may become unable to perform job at future date immaterial). The cases seem to rest upon a burden of proof upon the employer to show that there is more than a reasonable possibility of substantial harm if the applicant is employed.

101. Under federal and some state laws, employers must furnish a work environment free from any hazards likely to cause death or serious physical harm. OSHA, 29 U.S.C. § 654(a)(1) (1982). Furthermore, federal OSHA regulations say the employer cannot discharge or discriminate against employees who, in good faith, refuse to expose themselves to conditions they reasonably believe are dangerous. 29 C.F.R. § 1977.12(b)(2) (1987). The case law also supports the "good faith" protection under OSHA. See *Whirlpool Corp. v. Marshall*, 445 U.S. 1 (1980) (reasonable good faith belief is sufficient to provide OSHA protection). The reasonable and good faith elements mandate some form of employee education provided by the employer or a government agency. See, e.g., *Understanding AIDS*, *supra* note 74, at 261.

An employer simply cannot refuse to hire, if his or her basis for doing so is solely an applicant's handicap. Indeed, "discrimination against persons with AIDS should be presumed to come within the statutory protection of most jurisdictions unless the express working of the statute would contradict such a presumption." Leonard, *supra* note 79, at 1299. Employers could offer six reasons why employment was not possible: (1) fear of the disease; (2) fear of contagion; (3) health coverage under group policies coupled with employee abstenteeism; (4) fear it would hurt business; (5) futility in training an employee only to have him or her die soon afterwards; and (6) reluctance to jeopardize the health of the potential employee. *Id.* at 1299-1301.

102. The access employers are allowed to the medical records and information of their employees varies from state to state. See Survey, *supra* note 80, at 35. North Dakota allows an employer to require a medical examination and to enquire as to medical history. North Dakota Human Rights Act, N.D. CENT. CODE § 14-02.4-10(3)(a),(b) (Supp. 1987); Maine prohibits using questions on an application directly or indirectly pertaining to physical handicap where such information is necessary to protect the individual's health and also prohibits release of HIV test results. Maine Human Rights Act, ME. REV. STAT. ANN. tit. 5, § 4571(1)(D)(3) (1979). See also MASS. GEN. LAWS ANN. ch. 111, § 70F (West

questions raised by the *Arline* decision.¹⁰³

Although the issues raised by *Arline* remain unresolved, several government entities have formulated their own solutions. The Centers for Disease Control issued specific employment guidelines for certain classes of infected persons.¹⁰⁴ The United States Armed Forces test for HIV seropositivity and refuse enlistment or commission to those testing positive to the virus. And even though they may not be considered employees within the common use of the word, prisoners are currently subject to increased scrutiny.¹⁰⁵ States such as Illinois, Louisiana and Texas have recently passed legislation requiring pre-marital testing for HIV, and school boards are admitting children with AIDS to class-

Supp. 1988) (prohibits employers from requiring AIDS-virus test as condition for employment). Without specific state statutes, the issue of testing could revolve around testing for drug or alcohol abuse. See Geidt, *Drug and Alcohol Abuse in the Work Place: Balancing Employer and Employee Rights*, 11 EMPLOYEE REL. L.J. 181, 186-88 (1985). The refusal of Congress to include confidentiality in its passage of the October 13, 1988 AIDS appropriation bill deprives the issue of legislation and forces the issue into the courts to be discussed in relation to privacy. Nonetheless, additional legislation, such as the Americans with Disabilities Act, will present new opportunities to provide protection. See *Congress Approves Major AIDS Bill*, AIDS LAW REP., Oct. 1988, at 28.

103. See *AIDS and the Law: An Interview with Charles J. Cooper*, AIDS LAW REP., Nov. 1987, at 1 [hereinafter *Cooper*] (discusses possible future causes of action in areas of tort law and privacy). An October 1988 Justice Department memorandum suggested that § 504 of the Rehabilitation Act be applied to those persons demonstrating symptoms as well as those infected with the virus. See Memorandum from Douglas Kmiec, Assistant Attorney General, to Arthur Culverhouse, Jr., Counsel to the President (Sept. 27, 1988) (discussing application of section 504 of the Rehabilitation Act to HIV-infected individuals).

104. While the CDC has recommended against general employment restrictions because AIDS cannot be spread by casual contact, some specific precautions are recommended for particular work groups. See *Occupationally Acquired HIV Infections in Laboratories Producing Virus Concentrates in Large Quantities*, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 19-20 (Supp. Apr. 1, 1988) (health care workers); 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 1, 1-13 (Supp. Jan. 29, 1988) (school personnel); *Recommendations in Prevention of HIV Transmission in Health Care Settings*, 36 CDC MORBIDITY & MORTALITY WEEKLY REP. 3, 35-78 (Supp. Aug. 21, 1987) (health care workers); 35 CDC MORBIDITY & MORTALITY WEEKLY REP. 237, 237-41 (1986) (dental workers); 34 CDC MORBIDITY & MORTALITY WEEKLY REP. 681 (1985) (service personnel such as barbers and hairdressers).

105. Cases involving persons with AIDS in prison settings concern discrimination and fear more than health considerations. See, e.g., *Powell v. Department of Corrections*, 647 F. Supp. 968 (N.D. Okla. 1986) (court allowed segregation of prison inmate who tested positive, saying that Federal Constitution provided broad authority for prison officials); *Cordero v. Coughlin*, 607 F. Supp. 9 (S.D.N.Y. 1984) (persons with AIDS objected to segregation from general population, but judge found that segregation bore rational relation to goal of prison officials to safeguard those with AIDS from tensions and harm that could result from other prisoners' fears); *La Rocca v. Dalsheim*, 120 Misc. 2d 697, 467 N.Y.S.2d 302 (Sup. Ct. 1983) (prisoners sought to force prison officials to test other prisoners and employees for HIV and to remove those testing positive, but the judge refused to order testing, saying that disease was not spread by casual contact and their health and safety was not at risk).

rooms.¹⁰⁶ Thus, individual organizations and groups have formulated internal policies to help fill the legislative and judicial gap.¹⁰⁷

There is little doubt that most of the initial post-*Arline* litigation will focus on testing. Given the non-casual method of transmitting the virus, for most persons, testing prior to or during employment will be highly suspect¹⁰⁸ and it is likely that the individual's right of privacy will counter any compelling state interest.¹⁰⁹ Unless the virus mutates into a form that can be casually transmitted, individual privacy rights emanating from the penumbras of various provisions of the Bill of Rights, or specifically from the fourth amendment, will prevail over the employer's or government's countervailing interest.¹¹⁰

106. Several major school cases involving AIDS have been decided. *See* *Martinez v. School Bd.*, 692 F. Supp. 1293, 1305 (M.D. Fla. 1987) (court would not order a child into the classroom when the child's original treating physician recommended against it because the child was retarded, incontinent and drooling); *Doe v. Belleville Public School Dist.*, 672 F. Supp. 342, 344-45 (S.D. Ill. 1987) (child with AIDS not handicapped under The Federal Education for All Handicapped Children Act unless physical condition impairs educational performance); *Ray v. School Dist.*, 666 F. Supp. 1524 (M.D. Fla. 1987) (court ordered three brothers be readmitted to school so long as behavior not a health threat to others); *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376 (C.D. Cal. 1987) (child with AIDS bit another child's pants leg during fight but did not break the skin; judge ruled child must be readmitted to school since no substantial evidence that child posed a health hazard because of behavioral problems); *Bogart v. White*, No. 86-144, slip op. (Cir. Ct. Ind. Apr. 10, 1986) (twelve year old allowed to return to school even though state statute saying person with communicable disease could not attend; appeals court held child not infectious); *District 27 Community School Bd. v. Board of Educ.*, 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986) (names of children with AIDS could be kept private since children did not pose health risk).

107. Increasing numbers of schools, employers and even religious denominations are implementing policies on AIDS. *See, e.g., Creating an AIDS Policy: One Law Firm's Positive Experience*, AIDS LAW REP., Dec. 1987, at 1; *The Many Faces of AIDS: A Gospel Response*, 17 ORIGINS 481 (1987).

108. *See Legal Authorities on Effects of Arline*, 124 Lab. Rel. Rep. (BNA) 163 (1987). By October 1988, Washington, California, Iowa, Vermont, Maine, Hawaii, Florida and Massachusetts had statutes stating that an employer could not use or require a HIV test as a pre-condition for employment/hiring. STATE AIDS REPORTS, *supra* note 86, at 11. Nonetheless, both California and the District of Columbia each passed legislation providing for testing on the part of health, disability or life insurance companies. *California and District of Columbia Overtune AIDS Insurance Laws*, AIDS LAW REP., Oct. 1988, at 8 [hereinafter *Insurance Laws*].

109. In *Board of Medical Quality Assurance v. Gherardini*, 93 Cal. App. 3d 669, 679, 156 Cal. Rptr. 55, 61 (1979), the court held that the individual's right to privacy "encompasses not only the state of his mind, but also his viscera, detailed complaints of physical ills, and their emotional overtones." *Id.* *See* *Payton v. City of Santa Clara*, 132 Cal. App. 3d 152, 183 Cal. Rptr. 17 (1982) (information concerning reasons for personnel decisions). Drug testing is analogous, and the Supreme Court has only permitted testing under certain circumstances. *See* *Slanner v. Railway Labor Executives' Ass'n*, 109 S. Ct. 1402 (1989) (permitted testing of railroad employees); *National Treasury Employees Union v. Von Raab*, 109 S. Ct. 1384 (1989) (allowed testing of Customs employees who applied for positions involving drug interdiction or carrying of firearms).

110. Recently, the United States District Court for the District of Nebraska

But the issue is a sensitive one. Persons such as Charles Cooper, formerly with the United States Department of Justice, suggest that confidentiality "should not be taken to an extreme that interferes with legitimate public health efforts to protect uninfected members of the general public and prevent the spread of the disease."¹¹¹ Cooper argues for testing and disclosure of results to sexual partners, health care workers, potential marriage partners, hospital workers, and for the tracing of sexual partners of persons with AIDS. But the courts, groups like the American Medical Association and the American Hospital Association, and many state statutes disagree and argue for privacy¹¹² and many states guard the individual right to privacy with civil and criminal protections.¹¹³

What conclusions can then be drawn from the *Arline* decision? First, the case as written does not address itself directly to AIDS. Indeed, in a footnote, the majority of the Court writes that the "case does not present, and we therefore do not reach, the questions whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act."¹¹⁴ But *Arline* does parallel current AIDS cases particularly when the Court writes of Congress' intent to provide employment, forbid discrimination, and "respond rationally to those handicapped by a conta-

ruled that a multicounty mental retardation agency's policy of requiring certain employees to submit to mandatory testing for the human immunodeficiency virus violates the employees' fourth amendment rights. *Glover v. Eastern Nebraska Community Office of Retardation*, 686 F. Supp. 243, 250-51 (D. Neb. 1988).

111. See *Cooper*, *supra* note 103, at 1.

112. See, e.g., Confidentiality of Medical Information Act, CAL. CIV. CODE § 56 (West 1982 & Supp. 1989) (limiting the acquisition, use, and disclosure of medical information by health care providers and employers who seek or receive information from health providers). Furthermore, article 1, section 1 of the California Constitution provides: "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy." CAL. CONST. art. I, § 1. For a discussion of state statutory provisions prohibiting unauthorized release of confidential medical information, see Lipton, *Blood Donor Services' Liability and AIDS*, 7 J. LEGAL MED. 131 (1986). See also *Belle Bonfils Memorial Blood Center v. District Ct.* 763 P.2d 1003, 1013-14 (Colo. 1988) (plaintiff may not discover identity of blood donor, but may discover enough information to determine negligence of blood bank).

113. See W. PROSSER, D. DOBBS, R. KEETON & D. OWEN, *THE LAW OF TORTS* § 117 (5th ed. 1984) [hereinafter W. PROSSER & R. KEETON]; *RESTATEMENT (SECOND) OF TORTS* § 652D (1976); see also *Diaz v. Oakland Tribune, Inc.*, 139 Cal. App. 3d 118, 188 Cal. Rptr. 762 (1983) (sex change operation was found to be private); *MacDonald v. Clinger*, 84 A.D.2d 482, 446 N.Y.S.2d 801 (1982) (actionable to disclose personal information to patient's wife by psychiatrist).

114. *School Bd. v. Arline*, 480 U.S. 273, 282 n.7 (1987).

gious disease."¹¹⁵

Second, even though the dissenters in *Arline* write that the majority's view of the Rehabilitation Act cannot be correct because Congress would have to have expressed its intent, unambiguously,¹¹⁶ they also present the clear and convincing solution to the difficulty: Congress must pass legislation responding to *all* of the issues surrounding employment, discrimination and those handicapped by AIDS. Furthermore, inasmuch as the states share an identical interest in providing for the full employment of all citizens and the prohibition of discrimination, state statutes should be brought within the federal legislative penumbra by providing, as did the New York Court of Appeals in examining that state's Human Rights Law, that "[e]mployment may not be denied based on speculation and mere possibilities, especially when such determination is premised solely on the fact of an applicant's inclusion in a class of persons with a particular disability rather than upon an individualized assessment of the specific individual."¹¹⁷

The need to do this quickly is dramatized by the report of Admiral James D. Watkins, Chairman of the Presidential Commission on the HIV Epidemic (Presidential Commission), who characterized discrimination against HIV infected individuals as the "foremost obstacle to progress" in the AIDS crisis.¹¹⁸ Indeed, first among the major recommendations made by the Commission was: "Expansion of existing Federal handicapped antidiscrimination laws to the private sector as well as the public sector to include protection of those with HIV, as with other disabilities, from losing their jobs, educational opportunities, and homes."¹¹⁹

The need for expediency in addressing possible suits in the private sector is dramatized in the often-quoted *Tarasoff* rationale which could involve the case of a spouse being diagnosed by a physician as being seropositive.¹²⁰ In the 1976 California case, the California Supreme

115. *Id.* at 286 n.15.

116. *Id.* at 289 (Rehnquist, C.J., dissenting) (quoting *Pennhurst State School v. Halderman*, 451 U.S. 1, 17 (1981)).

117. *In re State Div. of Human Rights*, 70 N.Y.2d 100, 107, 510 N.E.2d 799, 802, 517 N.Y.S.2d 715, 718 (1987) (candidate for position of police officer with New York City disqualified because diagnosed as having presently asymptomatic back condition known as spondylolisthesis; appeals court ordered reinstatement).

118. J. WATKINS, CHAIRMAN'S DRAFT RECOMMENDATION FOR THE FINAL REPORT, PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 197-98 (1988) [hereinafter WATKINS REPORT]. This report was later adopted by the 13 member commission and submitted to the President of the United States. The Commission however, altered the final chapter to "delete Watkin's harsh criticism of the Administration's efforts" and some other recommendations were made. *Wash. Post*, June 19, 1988, at A16, col. 1.

119. WATKINS REPORT, *supra* note 118, at 3.

120. *Tarasoff v. Regents of the Univ. of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). Subsequent cases have limited this landmark case. *See Mavroudis v. Superior Ct.*, 102 Cal. App. 3d 594, 600-01, 162 Cal. Rptr. 724, 729 (1980) (court limited *Tarasoff* rule to cases where victims are read-

Court ruled that "the single relationship of a doctor to his patient is sufficient to support the duty to exercise reasonable care to protect others against dangers emanating from the patient's illness."¹²¹ This failure of a duty to warn could result in suits by spouses against physicians, hospitals and other health care groups.¹²² Rather than be protected by the doctor-patient privilege, the medical provider is made liable because of the special relationship created. The added dimensions of insurance, greater assets in the possession of physicians and others similarly situated, and the almost total elimination of charitable immunity, make spousal suits against those with a duty to warn probable.

Spouses also may bring suit for an employer's dismissal of the employed-infected spouse in violation of state or federal law.¹²³ While these suits have not yet been associated with the AIDS crisis, the recent decision in *Arline*, the subsequent broader interpretation of the federal Rehabilitation Act, and cases allowing tort actions to be brought against governments when there is a special relationship created by statute,¹²⁴ all portend greater use of statutes in assigning liability.¹²⁵ Such suits

ily identifiable); *In re Estate of Votteler*, 327 N.W.2d 759 (Iowa 1982) (no liability when victim already knows of a danger). In *Gammill v. United States*, 727 F.2d 950 (10th Cir. 1984), the Court of Appeals for the Tenth Circuit ruled that an army physician had no duty under Colorado law or the Federal Tort Claims Act to warn the neighbors of a hepatitis victim.

121. *Tarasoff*, 17 Cal. 3d at 433-39, 551 P.2d at 342-46, 131 Cal. Rptr. at 22-26.

122. *See, e.g., Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970) (court posited existence of reasonable duty to warn and advise members of patient's immediate family of existence and dangers of disease); *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919) (doctor has duty to warn parents of infectious nature of child's illness).

123. *R. O'BRIEN*, *supra* note 48, at 94-95. *See, e.g., Child Support Enforcement Amendments of 1984*, 42 U.S.C. § 1305 (Supp. 1986); D.C. CODE ANN. § 1-2512 (1981); MD. ANN. CODE art. 49B, § 16 (1986); VA. CODE ANN. §§ 51.5-40 to 51.5-46 (1988).

124. *See Turner v. District of Columbia*, 532 A.2d 662 (D.C. 1987) (court said that District of Columbia owed plaintiffs special duty of care beyond that owed general public by reasons of passage of Prevention of Child Abuse and Neglect Act). *See also Mammo v. State*, 138 Ariz. 528, 675 P.2d 1347 (Ct. App. 1983) (state held liable for breach of statutory duty for acting negligently in response to complaint of child abuse); *Florida First Nat'l Bank v. City of Jacksonville*, 310 So. 2d 19 (Fla. Dist. Ct. App. 1975) (cause of action against city where police failed to follow established police procedures in response to reports of child abuse); *Florence v. Goldberg*, 44 N.Y.2d 189, 375 N.E.2d 763, 404 N.Y.S.2d 583 (1978) (special relationship recognized where police failed to provide substitute for absent school crossing guard).

125. States are passing many statutes addressing varying AIDS related issues. "In 1984 there were approximately six bills introduced in state legislatures concerning AIDS. Last year [1987] there were over 550." *AIDS and State Policy*, AIDS LAW REP., Apr. 1988, at 3. *See also INTERGOVERNMENTAL HEALTH POLICY PROJECT, A SYNOPSIS OF STATE AIDS RELATED LEGISLATION*, (1987) [hereinafter *SYNOPSIS*] (available at George Washington University).

involving the employer may well provide greater incentive to all employers, not simply health care professionals, to learn all they can about AIDS.¹²⁶ Also, unless the federal, state and local governments enact specific grants of immunity, they too will become defendants in such liability suits.

D. *Insurance and Support: Shifting or Sharing?*

In the Spring of 1988, *The Washington Post* reported a summary of AIDS statistics by the National Center for Health Statistics. The summary is grim: "The number of hospital patients with AIDS rose 270 percent in two years, from 10,000 in 1984 to 37,000 in 1986 . . . and the patients had more than 1 million days of hospital care. About 95 percent . . . were men and 79 percent were between 25 and 44."¹²⁷ The report said that about 37,000 AIDS patients used 606,000 days of inpatient care during 1986, with an average stay of 16 days each time. The average hospital stay for other patients was 6.4 days.¹²⁸

The cost of caring for persons with AIDS seems extremely high.¹²⁹ Testimony before the Presidential Commission indicates that the AIDS-related hospital bill was \$380 million in 1985 and will probably reach greater than \$8.5 billion by 1991.¹³⁰ Total costs to the nation for AIDS, which include personal medical care and services, lost income, decreased consumption and insurance payouts, were approximately \$8.7 billion in 1986 and are projected to reach a total of \$66.5 billion in 1991, based on a projection of 173,000 cases of AIDS.¹³¹

However, there are those who conclude that "AIDS will *not* inflict a major impact on the economy through the early 1990s, [but] this does not mean it will not do so in the more distant future."¹³² While it cannot be overstated that AIDS is a personal and financial tragedy to persons, "compared to total spending on medical care, or deaths from all illnesses, the national economic impact of AIDS in the early 1990s will be small."¹³³ This is a perspective shared by Admiral Watkins who writes in his report that "[t]he costs of inpatient care for a person with

126. See generally Hermann, *AIDS: Malpractice and Transmission Liability*, 58 U. COLO. L. REV. 63, 107 (1986-87) ("liability may provide some measure of incentive to health care professionals to use proper diagnostic techniques").

127. Wash. Post, May 27, 1988, at A8, col. 1.

128. *Id.*

129. Andrulis, Beers, Bentley & Gage, *The Provision and Financing of Medical Care for AIDS Patients in U.S. Public and Private Teaching Hospitals*, 258 J. A.M.A. 1343, 1343 (1987) [hereinafter Andrulis].

130. WATKINS REPORT, *supra* note 118, at 27. See also Fineberg, *The Social Dimension of AIDS*, SCI. AM., Oct. 1988, at 128, 132-33; Fox & Thomas, *AIDS Cost Analysis and Social Policy*, 15 LAW, MED. & HEALTH CARE 186 (Winter 1987).

131. WATKINS REPORT, *supra* note 118, at 236.

132. Bloom & Carliner, *The Economic Impact of AIDS in the United States*, 239 SCIENCE 604, 609 (1988) [hereinafter Bloom].

133. *Id.*

AIDS are high, but are comparable to other high-cost medical conditions or illnesses."¹³⁴ If taken together, heart disease, stroke, cancer, and motor vehicle accidents account for about 20 percent of national medical expenditures. In 1986, total expenditures exceeded approximately \$425 billion.¹³⁵

As with the number of persons with AIDS and those estimated to develop AIDS, a reader can become anesthetized by the different estimates and the contradictory assessments concerning costs. These contradictions are, however, reconcilable. It is becoming increasingly apparent that the cost of AIDS differs according to geography, hospital ownership, and risk groups. In fact, an important lesson learned from the AIDS crisis is what might be called "striking variations."¹³⁶ This term represents more than the three factors of geography, hospital ownership and risk groups. Rather, it reveals some inherent contradictions in our health care financing system that, sparked by AIDS, will result in a departure from shifting responsibilities to sharing of the costs among multiple payers. As one commentator notes:

The growing number of patients who require expensive treatment finds payers scrambling to avoid responsibility for the costs. The private insurance sector is moving to limit its financial liability by restricting eligibility through the use of AIDS antibody testing or other screening mechanisms. The federal government, by denying disability benefits under Medicare, shifts the burden to the state and local levels. Private employers' efforts to control health care costs and the movement toward self-insurance have tended to reduce the cross-subsidies for providing care to the poor.¹³⁷

Health care professionals believe that the AIDS epidemic is highlighting tragic flaws in the health care system in America and, "[t]o the extent that traditional health insurers and self-insured businesses successfully evade responsibility for AIDS-related expenses, the financial burden will be shifted increasingly to the public sector."¹³⁸ This burden will be felt at the federal level through Medicaid expenditures, "and even more perniciously at the state and local levels through ever-larger contributions to Medicaid, indigent care programs, and faltering public hospitals."¹³⁹

134. WATKINS REPORT, *supra* note 118, at 236. Admiral Watkins reports that "[c]urrent estimates of lifetime hospital costs for a person with AIDS are under \$100,000 and annual treatment costs are approximately \$40,000. In comparison, the estimated costs of a liver transplant are \$175,000, of end-stage renal disease \$158,000, and of a heart transplant \$83,000." *Id.*

135. *Id.*

136. Andrulis, *supra* note 129, at 1345.

137. Arno, *The Economic Impact of AIDS*, 258 J. A.M.A. 1376, 1376 (1987).

138. *Id.* at 1377.

139. *Id.* Newspapers report the conflicts involving AIDS funding. See Rich,

In 1986, the Northeast region reported the most AIDS patients (3064), followed by the West (1234), South (802) and the Midwest (262). There was significantly lower Medicaid coverage and significantly more charity care in the South leading to the conclusion that reliance on charity or private insurance would be the rule in the South, with the governments assuming a higher burden in the other regions.¹⁴⁰ Moreover, "as of July 27, 1987, New York, San Francisco, and Los Angeles accounted for 45% of the nation's total AIDS caseload[.]"¹⁴¹ leading to the conclusion that "[r]esidents of those cities will pay higher taxes and health insurance premiums to finance a portion of the medical costs of local AIDS patients and may have increasing difficulty buying health insurance for themselves."¹⁴² Geography makes a difference in Medicaid, tax and insurance availability, and may well eventually mean that discrimination litigation will be more localized.¹⁴³

In reference to persons with AIDS, costs borne by private hospitals that are not reimbursed by other payers initially come from profits or from operating surpluses. With public hospitals, treatment not covered by patients, insurance, or other payers, will be borne by the local taxpayers. Again, geography will contribute to make some local taxes high. The choice between the two hospitals and certainly between payment or not will be made on the basis of private insurance. Nearly one-fourth of the adult population under the age of 65 is not covered by private health insurance.¹⁴⁴ It is not surprising that Medicaid is the most frequent payer in public hospitals, 62%, and that self-payment is quite high at 26%.¹⁴⁵ Major teaching hospitals and large public hospitals take on more than their share of the cost of caring for AIDS patients.¹⁴⁶ This situation calls for more innovative approaches to reducing the cost burden and still providing quality care.¹⁴⁷

Certain persons are more likely than others to acquire AIDS. The geographic location of these people as well as their availability to public

Bowen Hits Proposals to Curb State Medicaid, AIDS Funds, Wash. Post, Dec. 1, 1988, at A11, col. 1; *Congress Passes Compromise AIDS Bill*, N.Y. Times, Oct. 14, 1988, at A12, col. 1 (noting that confidentiality in testing was *not* approved).

140. Andrulis, *supra* note 129, at 1346.

141. Arno, *supra* note 137, at 1376. Hospital bills in New York City are projected to total from \$1.1 to \$2 billion in 1991. N.Y. Times, July 9, 1987, at A21, col. 3.

142. Bloom, *supra* note 132, at 609.

143. *Id.*

144. *Id.*

145. Andrulis, *supra* note 129, at 1344.

146. *Id.* at 1346. See also *Vacancies in Military Hospitals Seen as Helping in Drugs and AIDS Cases*, N.Y. Times, Nov. 28, 1988, at A22, col. 3.

147. In Dallas, Texas, there is an innovative approach to public assistance. There is an AIDS Resource Center, an outreach program of the Dallas Gay Alliance and the Foundation for Human Understanding. The Center coordinates a newspaper, *AIDS Update*, clothing bank, food pantry, support groups, visitation programs, media updates, an AIDS information number and other services.

or private hospitals will have a proportionate impact. The ages of 75% of those diagnosed with AIDS are between 25 and 44 years old; 87% of these are male; 42% are white, 34% are black and 21% are Hispanic. The highest number of cases involves homosexuals (47%) and heterosexual drug users (32%).¹⁴⁸ As these risk groups continue to represent disproportionate numbers of minorities within the nation, there is likely to follow a hidden agenda affecting the already-flawed health care system of the country. That is, the ability to care for members of society faced with catastrophic illness will continue to be severely compromised because of the care of the poor, the unemployed, and those too sick to maintain employment-related benefits.¹⁴⁹ Persons without AIDS will be affected by the burden placed on the overall national health care system.

Over time, as numbers and costs swell, the issue will evolve into cost sharing from what is now cost shifting among persons with AIDS and their families, private insurance companies, employers and employees, federal, state, and local taxpayers, and public and private hospitals. Financing is complex, placing particular burdens upon the poor or uneducated,¹⁵⁰ with the majority of care coming from hospitals. Some hospitals, like San Francisco General, St. Clare's and St. Vincent's in New York, and Johns Hopkins in Baltimore have a multi-disciplinary team of health care providers. Other hospitals have "scattered placements" which are more costly. To date, the costs are borne primarily by private insurance, Medicaid, and other state, local, and private monies.¹⁵¹

As the number of AIDS-infected persons increases, the cost of caring for them will eventually cause our present health care system to break down. The National Commission on Infant Mortality reported that by 1991 "there will be an estimated 10,000 to 20,000 cases of pediatric AIDS in the United States."¹⁵² If these infants remain in the hospital—and some do because they come from homeless families—the cost of maintaining that child in a municipal hospital pediatric ward for one

148. Andrulis, *supra* note 129, at 1344. Cf. *Syphilis Surge With Crack Use Raises Fears on Spread of AIDS*, N.Y. Times, June 29, 1988, at B1, col. 2.

149. Arno, *supra* note 137, at 1376. Arno is concerned over the burden to public hospitals, but the clear implication is that there is an interaction among all of the health care resources in the country. *Id.* at 1377.

150. The Presidential Commission noted that there are special populations with specific needs which differ from those of other population groups. WATKINS REPORT, *supra* note 118, at 17. But for the poor "[t]he problems of financing care for persons with AIDS . . . reflect the inequities in the entire U.S. health-care system in relation to the uninsured and the uninsurable, the plight of the poor in getting care and insufficient capabilities for care outside of institutions." *AIDS Panel Stresses Helping Addicts*, Wash. Post, June 2, 1988, at A4, col. 1 (quoting NAT'L ACAD. OF SCIENCES AND THE INSTITUTE OF MED., CONFRONTING AIDS (1986)).

151. WATKINS REPORT, *supra* note 118, at 27.

152. *Id.* at 17.

year is in excess of \$250,000.¹⁵³ The number of adults will be at least thirty times the number of children and, if the adult is a drug user, the costs will be even greater.¹⁵⁴ Medical advances will affect the costs as well. For example, the drug azidothymidine (AZT) increases the life expectancy of persons with AIDS without curing them. AZT costs at least \$8,000 per patient per year and has side effects that may require patients to have frequent blood transfusions.¹⁵⁵ Surely, as patients and costs escalate, there will be increasing calls to devise a system to share the costs among all concerned.

However, the *present* legal struggle involves HIV testing by insurance companies to screen applicants for health, life or disability insurance.¹⁵⁶ The response of most states to insurance company testing is that such testing discriminates or breaches the applicant's privacy. Most of the state statutes *introduced* in 1987 prohibited insurance companies from testing, releasing information, cancelling coverage or changing rates.¹⁵⁷ Individual states are certainly concerned that "the price for AIDS-related expenses must be met . . . [and] those expenses not covered by insurance companies (and hence passed along to other policyholders in the form of higher premiums) will be picked up, finally, by the government, which will perforce pass along the expense to the general population in the form of higher taxes."¹⁵⁸ But in order to remain competitive among other insurance companies and in an effort to "underwrite HIV infected people exactly as we underwrite all other people whether they have hypertension, anemia, or heart disease,"¹⁵⁹ companies are seeking to place persons within categories without requiring testing or direct questions.¹⁶⁰ These categories will determine premiums and benefits.

153. *Id.* at 28.

154. Bloom, *supra* note 132, at 604. The article purports to show that it is impossible to accurately gauge the cost of caring for a person with AIDS. *Id.* Bias, underestimation and comparison of nonpersonal and personal medical bills affect any cost analysis. See also Arno & Hughes, *Local Policy Responses to the AIDS Epidemic: New York and San Francisco*, 87 N.Y. STATE J. MED. 264, 264-72 (1987).

155. Wall St. J., Dec. 15, 1987, at 36, col. 3. See generally Wash. Post, June 14, 1988 at HE7, col. 2, (stating that "researchers . . . said that the three-drug combination of Adriamycin, Bleomycin and Vincristine produced an 87 percent response rate against Kaposi's sarcoma tumors, and for nearly a third of the AIDS patients, the cancer disappeared completely").

156. See generally R. O'BRIEN, *supra* note 48, at 96-99.

157. See SYNOPSIS, *supra* note 125, at 51-55.

158. NATIONAL LEGAL RESEARCH GROUP, THE AIDS LAW REPORT 11 (1987).

159. Grieco, *AIDS: Legal Aspects of a Medical Crisis*, *Medical Facts Related to Legal Issues*, 1986 A.B.A. SEC. TORT & INS. PRAC. 5.

160. Insurers can ask questions on an application about marital status, age, sex of the beneficiary, the nature of the applicant's neighborhood, sexual preference, or require a full medical checkup without the HIV test. Such questions provoke additional state concern over fair business and anti-discrimination statutes, but they permit the company a degree of flexibility.

Today, nearly 85% of all health and life insurance policies are covered under group plans. Most of these plans require little or no medical information on individual policyholders and pre-existing conditions are certainly accepted with a nonchalance that would not be tolerated if an individual were applying for a single policy for himself or herself. As the number of persons and the costs associated with AIDS escalate, the nature and coverage of these group policies will certainly be affected.

In the battle over health, disability and life insurance both within the courts and the legislatures, proponents and opponents argue over rights, costs and fairness.¹⁶¹ When the statistics are reviewed, it is difficult to foresee any winners in such a fracas. The better approach will lie in adopting a cost sharing rationale, rather than shifting cost responsibility.

Legislation introduced by Senator Moynihan appears to be establishing the necessary framework for eventual sharing of costs.¹⁶² By making Medicare and Medicaid, the two primary forms of government reimbursement for health care, more suitable for the treatment of AIDS, this legislation will enhance the benefits of both private insurance and public assistance. Bills were introduced to waive the twenty-four month waiting period for Medicare for those persons with AIDS receiving Social Security Disability Insurance,¹⁶³ and also to provide Medicaid coverage for community and home-based services. Realizing the uniqueness of AIDS helps to better utilize insurance companies', hospitals' and patients' resources. Since private or employer based health insurance often runs out quite quickly, the patient is left destitute while waiting for the Social Security disability payments to begin. Moreover, since patients with AIDS often do not live for more than twenty-four months, the previously required time to qualify for disability payments, these patients are unable to utilize the disability benefits. Also, by providing for Medicaid coverage for community and home-based services, the federal

161. In October 1987, the insurance companies received two important boosts in their efforts to allow testing for HIV in the determination of insurability. A Massachusetts court struck down a proposed regulation that would prohibit HIV testing for insurance purposes, and in the District of Columbia, Congress passed a rider on the District's budget appropriations bill requiring the city to repeal the strongest law in the nation banning testing or lose \$200 million in federal funding. See *Insurers Winning Battles in Massachusetts & District of Columbia*, AIDS LAW REP., Nov. 1987, at 4.

162. See *AIDS: A Federal Response*, Hearings on S. 24 Before the Finance Subcommittee on Social Security and Family Planning, 100th Cong., 2d Sess. 1-5 (1987) (opening remarks of Senator Moynihan, Chairman). Senator Moynihan stated that out of 84 measures introduced dealing with AIDS in the past three Congresses, there have been essentially only two major bills dealing with Medicare and Medicaid. *Id.* at 1-2.

163. New Jersey and New Mexico were the first states to use this § 2176 of the Omnibus Budget Reconciliation Act of 1981; California was just approved. New York has instituted an option program to provide a range of services, badly needed in a city which will need 1,300 to 1,500 beds by 1991 to care for persons with AIDS.

government is expanding the alternatives to expensive hospital care, alternatives critically needed by the teaching and public hospitals.¹⁶⁴ But even with the suggested improvements, the present system is woefully inadequate. For instance:

The average national inpatient costs of caring for a patient with AIDS has been estimated at about \$630 per day. The Medicaid reimbursement rate, however, in the South averages about \$282 per day and in other regions of the country about \$500 per day.

Care for a person with AIDS in a long-term care institution can cost an estimated \$200 per day, but in most states Medicaid reimburses only about \$50 per day. State Medicaid programs also do not adequately cover outpatient services, needed by community-based programs to help individuals with AIDS.¹⁶⁵

The core of the problem is that both public and private payers set limits on the benefits each is to provide without examining the rights and responsibilities of the other. This problem is complicated by the fact that the public payer is both federal and state. Also, there is an attitude that has been described as shifting of responsibility, which encourages each party, public or private, to seek to avoid as much of the economic burden as possible. The Presidential Commission heard testimony that rejected this approach as foolhardy. In place of cost shifting Admiral Watkins recommends:

The Health Care Financing Administration (HCFA) should establish a demonstration project which increases the federal Medicaid matching rate for states that give providers a higher rate for promoting long-term care, comprehensive home care, outpatient services, and case management of a full range of services, *including coordination with other providers*, to encourage cost-effective care for AIDS patients. . . .

The federal government should encourage all states to enact a qualified state pool for medically uninsurable individuals and provide technical assistance to ensure adequate coverage, financing from a *combination of private and public sector funds*, adequate provision of benefits, and mandated case management. . . .

The federal government should require that all patients using 50 percent or more federal dollars for their care participate in a case managed system.¹⁶⁶

164. The Federal Health Resources and Services Administration is currently evaluating the costs of out-patient and clinical services to determine cost effectiveness of patient support services.

165. WATKINS REPORT, *supra* note 118, at 237.

166. *Id.* at 241-46 (emphasis added).

These recommendations, with few exceptions, place the burden of care on insurance or on federal and state programs. But in addition to an individual being responsible to pay part of the cost of his or her care, there is authority for the position that a parent is responsible for the support of a child,¹⁶⁷ that this duty to support a child could extend beyond the age of majority,¹⁶⁸ and that one spouse has the duty to support the other. In addition, some state statutes require responsible adult children to support needy or poor elderly parents and provide that the children must reimburse the state for support provided by it to the parents.¹⁶⁹ As recommended in Admiral Watkins' report, the resources of all, not just public and private funds, will need to be considered if there is to be fairness in sharing responsibility for costs.

E. *Living Wills, Durable Power of Attorney and Testamentary Issues*

Perhaps it is true with cancer or with any other lengthy terminal illness, but it is certainly true with AIDS that every person confronting the disease thinks about legal means by which he or she might lessen the pain and minimize the grief and burden for members of the family.¹⁷⁰ This can be accomplished by various means such as a living will, durable power of attorney, will substitutes and a last will and testament.

1. *Living Wills*

It is difficult to describe a living will. While it is often associated with such descriptive phrases as "right to die," "death with dignity," or "natural death," the term actually describes the document signed by a person allowing families and health providers to restrict the extraordinary means that can be taken to prolong the dying person's life while protecting them from any liability for "allowing [the patient] to die."¹⁷¹ Today, nearly every state has a legal mechanism by which an adult may restrict the extraordinary means that can be taken to prolong life. While

167. See R. O'BRIEN, *supra* note 48, at 98-99. This duty to support a child extends to stepparents, and in Delaware, to a person who cohabits with the parent of a minor child. DEL. CODE ANN. tit. 13, § 501(b) (1981). The duty arises only if the natural parent is unable to provide for the child's minimum needs. *Id.*

168. Many states require post-majority support for disabled children. See, e.g., ARIZ. REV. STAT. ANN. § 25-320(B) (Supp. 1988); TEX. FAM. CODE ANN. § 14.05(b) (Vernon 1987). For judicial construction, see *Sininger v. Sininger*, 300 Md. 604, 479 A.2d 1354 (1984). Without disability and without permission of a statute, the duty of support ends at majority. See *Birchfield v. Birchfield*, 417 N.W.2d 891 (S.D. 1988).

169. *In re Jerald C.*, 36 Cal. 3d 1, 5, 678 P.2d 917, 918, 201 Cal. Rptr. 342, 343-44 (1984). See also *Swoap v. Superior Court*, 10 Cal. 3d 490, 502, 516 P.2d 840, 848, 111 Cal. Rptr. 136, 144 (1973).

170. C. DAVIS, *supra* note 53, at 196.

171. See Flanagan, *The Right to Die: Opening Communications, Making Decisions*, AIDS PATIENT CARE, Oct. 1988, at 34 (discussion of living wills).

each case is unique, there is a passage from *And the Band Played On* that captures the effect of such a decision:

There were conversations with every patient about code status. Upon respiratory failure from, say, *Pneumocystis pneumonia*, a patient could ask for code-blue status, a request that hospital staff use all necessary means to preserve his life. Usually that meant a respirator. After two years of experience with AIDS patients, however, doctors found that 85 percent of *Pneumocystis* sufferers who went on a ventilator never came off the contraption. They died a miserable and silent death, with a tube stuck down their throats. In Ward 5B, most patients opted to go without the code blue, asking that no extraordinary measures be used to preserve their lives. In the months to come, more patients . . . made that choice than in all the other hospital wards combined.¹⁷²

For many persons with AIDS, as it must be with others facing terminal illness, "a point is often reached where maintenance of an individual is in defiance of all concepts of basic humanitarianism and social justice."¹⁷³ Many argue that "[w]hen an individual's condition is such that it represents a negation of any 'truly human' qualities or relational-potential, then the best form of treatment should be arguably no treatment at all."¹⁷⁴ This is the rationale behind a living will, a rationale that prompted California, and twenty-six other states, to enact the first statutes recognizing these documents.

Recently, however, the Society for the Right to Die and various other litigants were involved in the case of a New York man who had been diagnosed as having an AIDS-related complex.¹⁷⁵ In preparation, the man had signed a living will specifying that treatment should be withheld if there was "no reasonable expectation of recovering or regaining a meaningful quality of life." This is a standard clause in living wills. When this person was admitted to the hospital with toxoplasmosis, he was comatose and unable to comment on treatment. Thus, physicians prescribed aggressive antibiotic treatments because they thought the condition was treatable. Nonetheless, the proxy appointed

172. R. SHILTS, *supra* note 4, at 355.

173. Smith, *Death Be Not Proud: Medical, Ethical and Legal Dilemmas in Resource Allocation*, 3 J. CONTEMP. HEALTH L. & POL'Y 62 (1987).

174. Smith, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis?*, 63 NEB. L. REV. 709, 733 (1984); Smith, *Triage: Endgame Realities*, 1 J. CONTEMP. HEALTH L. & POL'Y 143, 149-50 (1985). See also Evans, Blagg & Bryan, *Implications for Health Care Policy: A Social and Demographic Profile of Hemodialysis Patients in the United States*, 245 J. A.M.A. 487, 490 (1981); Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 WIS. L. REV. 239; Malcom, *Fateful Choice in Fatal Illness: How Long to Live*, N.Y. Times, Feb. 14, 1986, at A12, col. 2.

175. The case, without citations, is discussed in *AIDS In the Courts*, AIDS REP., Feb. 1988, at 2.

in the living will went to court to stop treatment under the terms of the living will. The judge did not enforce the terms of the living will as requested by the proxy because the words "no reasonable expectation" and "meaningful quality of life" were too ambiguous to be enforced effectively.

Eventually, the patient became progressively ill and the physicians did in fact withhold treatment, allowing the person to die. The terms of the living will were thus upheld, but not without identifying a need to eliminate any ambiguities in the instruments.¹⁷⁶ Indeed, as AIDS progresses, the responsibility will belong to the state legislatures to provide unambiguous guidelines and even forms by which persons may direct what may be withheld, when it may be withheld, and who may make the ultimate decisions.

2. *Durable Powers of Attorney*

Most persons are familiar with a power of attorney. It can be defined as an instrument authorizing another to act as one's agent or attorney.¹⁷⁷ Likewise, terms such as trustee or personal representative are familiar to many people; some persons are even cognizant of powers of appointment. But most people are unaware that in 1969, the National Conference of Commissioners on Uniform State Laws published powers of attorney [later to be called "durable powers of attorney"] to assist persons interested in establishing non-court regimes for the management of their affairs in the event of later incompetency or disability. The purpose was to recognize a form of senility insurance comparable to that available to relatively wealthy persons who use funded, revocable trusts when they "are unwilling or unable to transfer assets as required to establish a trust."¹⁷⁸ The durable power was to alter the common law rule that restricted the ability of the attorney to the good health of the principal.

A variety of state statutes have been enacted since 1969, especially since 1977, when the National Conference published a comprehensive Act and established durable powers as a "supplement enabling nomination of the principal's choice for guardian to an appointing court and continuing to authorize efficient estate management under the direction of a court appointee."¹⁷⁹ The Act's definition contains the important features of the power:

A durable power of attorney is a power of attorney by which a

176. *Id.*

177. BLACK'S LAW DICTIONARY 1055 (5th ed. 1979).

178. J. LANGBEIN & L. WAGGONER, SELECTED STATUTES ON TRUST AND ESTATES 333 (1987). The only requirement is that an instrument creating a durable power contain language showing that the principal intends the agency to remain effective in spite of his later incompetency.

179. *Id.* at 334.

principal designates another his attorney in fact in writing and the writing contains the words "This power of attorney shall not be affected by subsequent disability or incapacity of the principal, or lapse of time," or "This power of attorney shall become effective upon the disability or incapacity of the principal," or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the principal's subsequent disability or incapacity, and unless it states a time of termination, notwithstanding the lapse of time since execution of the instrument.¹⁸⁰

Once the power becomes effective, "[a]ll acts done by an attorney in fact pursuant to a durable power of attorney during any period of disability or incapacity of the principal have the same effect and inure to the benefit of and bind the principal and his successors in interest as if the principal were competent and not disabled."¹⁸¹ The attorney is to serve until the appointment is revoked or he or she is replaced by another. If, after execution of a durable power of attorney, a court of the power grantor's domicile appoints a fiduciary (such as a conservator or guardian) "charged with the management of all of the principal's property . . . , the attorney in fact is accountable to the fiduciary as well as to the principal."¹⁸² Thus, the link is established between an attorney as one who assumes responsibility upon disability, and a fiduciary (personal representative under a valid last will and testament or an administrator as in intestacy) who is appointed by the probate court to administer the property of the principal now deceased.

As with living wills, this is an area of the law that is best resolved through clearly defined statutes with accompanying forms which eliminate subsequent litigation. Particularly in the case of homosexual persons living in non-marital relationships with life-companions or lovers, avoidance of conflicts with traditional family members can be achieved through proper use of durable powers.¹⁸³

3. *Testamentary Issues*

In addition to living wills and durable powers of attorney, valid testamentary dispositions are important. This concerns the valid disposition of property through gifts during life, a variety of will substitutes including insurance, deeds, joint bank accounts or trusts, and of course

180. UNIF. PROBATE CODE § 5-501, 8 U.L.A. 88 (Supp. 1988). Because of litigation over the use of ambiguous words in living wills, it may be wise to draft a more precise point at which effectiveness begins. More may be needed than a reference to a later condition of "disability or incapacity."

181. *Id.* § 5-502, 8 U.L.A. 89 (Supp. 1988).

182. *Id.* § 5-503(a), 8 U.L.A. 514 (1983).

183. For an example of typical family conflicts arising in situations where the AIDS victim is homosexual, see R. SHILTS, *supra* note 4, at 395.

a valid last will and testament. Persons suffering from a terminal illness can utilize all of these, but those anticipating even a remote possibility of conflict or litigation from "interested persons"¹⁸⁴ would be wise to construct a distribution scheme that would eliminate protracted litigation based on undue influence, lack of testamentary capacity, insane delusion, fraud or mistake. Expensive and protracted probate contests can be avoided through inter vivos gifts, creating jointly held ownership in property with rights of survivorship or, where this can be accomplished without perpetrating fraud upon an insurance company, executing contracts of life insurance to be paid to named beneficiaries.

Undue influence is likely to be the major ground of a will contest and particular care should be taken to avoid establishing what the law calls a "rebuttable presumption of undue influence."¹⁸⁵ Because the family may object to a stranger taking property,¹⁸⁶ there may be resentment over the testator's relationship with a friend or lover,¹⁸⁷ or a sense that the bequest or devise was the result of unfair or unethical conduct. Professor Haskell notes that "findings of undue influence often reflect a sense of offense at what has occurred."¹⁸⁸ Because interested persons often have three years after the death of the decedent to challenge a will, the offense can smolder for a long time.

In the past fifteen years statutes and common law doctrines have arisen that provide greater control over dignity, wealth, and personal choice. Among these are living wills, durable powers of attorney and alternatives to last wills and testaments, commonly called will substitutes. All of these can and should be utilized within the family as a means of responding to the wishes and expectations of a person with AIDS.

F. *Nonmarital Contracts*

One of the most common family-type living arrangements to emerge in recent years involves persons of the same or opposite sex,

184. For examples of those parties considered "interested," see UNIF. PROBATE CODE § 1.201(20), 8 U.L.A. 32 (1983).

185. Even though the burden of proof is upon a contestant, the contestant may in some jurisdictions establish a rebuttable presumption of undue influence when the following factors are present: "(a) A testator is susceptible to undue influence; (b) a confidential relationship exists between the testator and the person allegedly exercising the influence; and (c) a testamentary gift to the confidante or to someone in who he or she has an interest which is unnatural or unusual." P. HASKELL, PREFACE TO WILLS, TRUSTS AND ADMINISTRATION 41 (1987).

186. See, e.g., *Estate of Baker*, 131 Cal. App. 3d 471, 182 Cal. Rptr. 550 (1982); *In re Estate of Borsch*, 353 N.W.2d 346 (S.D. 1984).

187. See, e.g., *In re Dilios' Will*, 165 Me. 508, 167 A.2d 571 (1960); *In re Will of Moses*, 227 So. 2d 829 (Miss. 1969); *In re Kaufmann's Will*, 20 A.D.2d 464, 247 N.Y.S.2d 664 (1964), *aff'd*, 15 N.Y.2d 825, 205 N.E.2d 864, 257 N.Y.S.2d 941 (1965); *In re Kelly's Estate*, 150 Or. 598, 46 P.2d 84 (1935).

188. P. HASKELL, *supra* note 185, at 45.

over the age of majority, living together in a family-type of relationship identified by contract rather than marriage, statutory or common law.¹⁸⁹ The contract may be either express or implied, but since the early 1970s and the well publicized dispute between Michelle and Lee Marvin, courts have demanded that the relationship, "be supported by some recognized underlying obligation in law or equity."¹⁹⁰ With the exception of those courts which refuse to enforce such contracts on public policy grounds, there has been general acceptance of rights arising in contexts where the partners share sexual relationships.¹⁹¹

Moreover, even if there are objections to the use of nonmarital contracts, an argument can be made that the state should not have a monopoly on private relationships.¹⁹² Indeed, the state could recognize the utilitarian value of such relationships with the same degree of enthusiasm that it held for the de facto status of common law marriages.¹⁹³ But, because many states¹⁹⁴ still consider sexual relations between unmarried persons to be criminal and the possibility that nonmarital con-

189. See generally Fineman, *Law and Changing Patterns of Behavior: Sanctions on Non-marital Cohabitation*, 1981 WIS. L. REV. 275 (discussing legal system's response to cohabitation); Kay & Amyx, *Marvin v. Marvin: Preserving the Options*, 65 CALIF. L. REV. 937 (1977); Reppy, *Property and Support Rights of Unmarried Cohabitants: A Proposal for Creating a New Legal Status*, 44 LA. L. REV. 1677 (1984); Younger, *Marital Regimes: A Story of Compromise and Immoralization, Together with Criticism and Suggestions for Reform*, 67 CORNELL L. REV. 45 (1981); Annotation, *Property Rights Arising from Relationship of Couple Cohabiting Without Marriage*, 3 A.L.R.4th 13 (1979).

190. *Marvin v. Marvin*, 122 Cal. App. 3d 871, 876, 176 Cal. Rptr. 555, 559 (1981). For an analysis of these issues formulated prior to the first *Marvin* decision, see Bruch, *Property Rights of De Facto Spouses Including Thoughts on the Value of Homemaker Services*, 10 FAM. L.Q. 101 (1976). For a decidedly anti-*Marvin* approach, see *Hewitt v. Hewitt*, 77 Ill. 2d 49, 394 N.E.2d 1204 (1979) (using public policy rather than contract analysis).

191. See, e.g., *Artiss v. Artiss*, 8 FAM. L. REP. 2313 (1st Cir. 1982); *Dosek v. Dosek*, 4 FAM. L. REP. 2828 (Conn. Super. Ct. 1978); *Mason v. Rostad*, 476 A.2d 662 (D.C. 1984); *Poe v. Estate of Levy*, 411 So. 2d 253 (Fla. Dist. Ct. App. 1982); *Donovan v. Scuderi*, 51 Md. App. 217, 443 A.2d 121 (1982); *Kozlowski v. Kozlowski*, 80 N.J. 378, 403 A.2d 903 (1979); *Marone v. Marone*, 50 N.Y.2d 481, 413 N.E.2d 1154, 429 N.Y.S.2d 592 (1980).

192. See Kandoian, *Cohabitation, Common Law Marriage, and the Possibility of a Shared Moral Life*, 75 GEO. L.J. 1829, 1872 (1987) ("Taking public vows or engaging in perfunctory bureaucratic requirements are not the only ways intimate partners can express full commitment to one another, just as seals are not the *sine qua non* of contract.").

193. Even though states have and are abolishing common law marriage, there was a time when such marriages were accepted as recognizing a societal reality. See *McCoy v. District of Columbia*, 256 A.2d 908 (D.C. 1969); *In re Redman's Estate*, 135 Ohio St. 554, 21 N.E.2d 659 (1939). This is not true today. *In re Manfredi's Estate*, 399 Pa. 285, 159 A.2d 697 (1960).

194. See GA. CODE ANN. § 16-6-18 (1984) (fornication between unmarried persons is misdemeanor); ILL. ANN. STAT. ch. 38, para. 11-8 (Smith-Hurd 1979) (fornication between two unmarried persons is misdemeanor); VA. CODE ANN. § 18.2-344 (1988) (prohibits intercourse out of wedlock).

tracts could be entered by persons of the same sex,¹⁹⁵ many courts and legislatures are prone to afford these relationships nothing more than grudging status.

But the fact remains that many persons live in such nonmarital relations; perhaps as many as 2.2 million couples in the United States were living together without any form of marriage in 1986.¹⁹⁶ The chief issue for both these couples and society is determining the parameters of each partner's financial responsibility for the other. This problem arises even if there is an express contract because the newness of this type of relationship leaves the courts without much statutory or common law guidance. Among the major problems presented in this context are: 1) the nature and extent of each person's duty; 2) whether the parties to the agreement understood their contractual obligations; and 3) regardless of their understanding, whether society should impose obligation anyway just as it does with married persons.

As with all contractual arrangements, the actual contract involved is very important. With the advent of the new Uniform Premarital Agreement Act¹⁹⁷ presently being adopted or considered by various states, there is greater knowledge and acceptance of what can be determined by an agreement-contract.¹⁹⁸ Any contract should include at least the following:

- (1) The rights and obligations of each of the parties in any of the property of either or both of them whenever and wherever acquired or located;
- (2) The right to buy, sell, use, transfer, exchange, abandon, lease, consume, expend, assign, create a security interest in,

195. See Note, *The Legality of Homosexual Marriage*, 82 YALE L.J. 573 (1973). There is increasing litigation concerning homosexual status vis-a-vis homosexual activity. See *Watkins v. United States Army*, 837 F.2d 1428 (9th Cir.) (army regulations violated equal protection guarantee by discriminating against persons of homosexual orientation without promoting legitimate compelling governmental interests), *rehearing ordered*, 847 F.2d 1362 (9th Cir. 1988).

196. U.S. BUREAU OF CENSUS, DEP'T OF COMMERCE, CURRENT POPULATION REPORTS, HOUSEHOLDS, FAMILIES, MARITAL STATUS AND LIVING ARRANGEMENTS 2 (1986).

197. UNIF. PREMARITAL AGREEMENT ACT § 2, 9 U.L.A. 334 (1985). Even though the Act is defined as one between prospective spouses made in contemplation of marriage and to be effective upon marriage, the elements within the Act can serve as ingredients for persons of the same or opposite sex wishing to establish a contractual relationship.

198. Well before the Premarital Agreement Act, authors were discussing the elements of a fair and comprehensive contract. See, e.g., L. WEITZMAN, *THE MARRIAGE CONTRACT* (1981); Clark, *Antenuptial Contracts*, 50 U. COLO. L. REV. 141 (1979); Fleischmann, *Marriage by Contract: Defining the Terms of Relationship*, 8 FAM. L.Q. 27 (1974); Weitzman, *Legal Regulation of Marriage: Tradition and Change*, 62 CALIF. L. REV. 1169 (1974). Authors have continued to address the issue. See Temple, *Freedom of Contract and Intimate Relationships*, 8 HARV. J.L. & PUB. POL'Y 121 (1985); Comment, *Recurrent Patterns of Family Law*, 8 HARV. J.L. & PUB. POL'Y 175 (1985).

mortgage encumber, dispose of, or otherwise manage and control property;

(3) The disposition of property upon separation, marital dissolution, death, or the occurrence or nonoccurrence of any event;

(4) The modification or elimination of spousal support;

(5) The making of a will, trust, or other arrangement to carry out the provisions of the agreement;

(6) The ownership rights in and disposition of the death benefits from a life insurance policy;

(7) The choice of law governing the construction of the agreement;

(8) Any other matter, including personal rights and obligations not in violation of public policy or a statute imposing a criminal penalty.¹⁹⁹

These agreements are not limited to marriage. Since public policy restrictions have been lifted, they are available to other adults living in alternative arrangements. But in order to provide for proper implementation, local statutes and practice manuals should be consulted. All will likely suggest the following guidelines:

1. Avoid any fraud: This is the intentional misrepresentation of a material fact upon which the other party relied to his or her detriment. It is quite conceivable that living a high-risk lifestyle, the use of drugs, or HIV positive status would be material.

2. To maintain fairness, make full disclosure of all financial arrangements, to include income taxes and perhaps even availability for insurance coverage.

3. Avoid any reference to sexual services as the primary consideration for entering into the contract. A desire to purchase a safe-sex partner would be an example of what to avoid.

4. Refer to the arrangement as a contract and not as a substitute for marriage. States regard marriage as a contract to which they are a part and the ability to enter into that contract will be closely scrutinized.²⁰⁰

5. Consult local guidelines for inclusion of specific elements.

199. UNIF. PREMARITAL AGREEMENT ACT § 3(a), 9 U.L.A. 334 (1985). Subject to public policy and other state statutes, the agreement could establish procedure for resolving disputes over names, aims and expectations, educational expenses to include payment and future expectations in the degree or certificate, and even household responsibilities.

200. See *Hewitt v. Hewitt*, 77 Ill. 2d 49, 394 N.E.2d 1204 (1979) (Illinois court refused to recognize implied agreement because parties had in fact intended marriage and common law marriage had been abolished); *Singer v. Hara*, 11 Wash. App. 247, 522 P.2d 1187 (1974) (persons of same sex cannot enter into marriage relationship as that relationship is understood by state).

This is especially important regarding children (support and custody), community property distribution, and reimbursement of share of future earnings associated with advanced degrees.

Because these agreements can be utilized by homosexuals and persons wishing to form a family-type unit without entering into the traditional marriage, they offer important protection. Nonetheless, nonmarital contracts should be examined, drafted and implemented carefully. Each has consequences that affect support, estate planning and human relationships.

III. MARITAL ISSUES: HUSBAND AND WIFE

A. *Suits for Annulment*

When a state is asked to dissolve a marriage on the basis of annulment, it begins with the premise that the marriage is valid and its existence serves a legitimate public interest. Indeed, through such doctrines as putative spouse,²⁰¹ common law marriage, validation,²⁰² ratification,²⁰³ presumption of validity of the second marriage,²⁰⁴ and a limit upon the time in which a suit may be brought,²⁰⁵ states announce a premise of validity affecting marriage. Indeed, some states, such as Texas, expressly codify this policy:

[I]n order to provide for stability for those entering into the marriage relationship in good faith and to provide legitimacy and security for the children of the relationship, it is the policy of this state to preserve and uphold each marriage against claims of invalidity unless strong reasons exist for holding it void or voidable.²⁰⁶

Against this background, annulment can be seen as a harsh measure, one taken only when there are significant public policy reasons.

201. See, e.g., CAL. CIV. CODE §§ 4452, 4455 (West Supp. 1989).

202. TEX. FAM. CODE ANN. § 2.23 (Vernon 1975) ("Except for marriages that would have been void under Section 2.21 of this code [consanguinity], all marriages . . . are validated from the beginning if the parties continued . . . to live together as husband and wife and to represent themselves to others as being married.").

203. While validation can be applied to "bring about" void marriages, ratification is a term associated with those situations where the marriage could be annulled for a lesser reason, but the party who could bring suit has acquiesced in the situation. See TEX. FAM. CODE ANN. §§ 2.41-2.46. See also *Christoph v. Sims*, 234 S.W.2d 901 (Tex. Ct. App. 1951) (petitioner was married under influence of alcohol or narcotics and then voluntarily cohabited with other party after influence of alcohol or narcotics ended).

204. TEX. FAM. CODE ANN. § 2.01 (presumption of validity for most recent marriage).

205. *Id.* § 2.47.

206. *Id.* § 2.01.

Traditionally, those significant reasons have been bigamy, incest,²⁰⁷ and radical underage.²⁰⁸ Needless to say, persons of the same sex are also barred from marriage.²⁰⁹ These would all be reasons for making a marriage "void." Lesser reasons serving as "voidable" grounds for annulment would include: fraud, duress, mental incompetence, nonage, epilepsy, impotence, jest, venereal disease, alcoholism, narcotics, or force. Whether the grounds for the annulment make the marriage void or voidable depends upon the state statute. The significance of the difference will be reflected in the persons who can sue for annulment, the length of time to sue, and perhaps increasingly with statutory reform, the availability of the ground itself. With the advent of no-fault divorce, states have begun to abolish voidable grounds for annulment,²¹⁰ and it is doubtful that these grounds will ever regain any of the prominence they might once have had.

The one exception to this trend is fraud. Fraud is important in reference to AIDS and HIV positivity because annulment of a prior valid marriage based on fraud is authorized by statute in thirty states and the District of Columbia and under the common law in other jurisdictions.²¹¹ There is no reason to think that fraud will not continue to be a ground in the future based on the theory that the defrauding party misrepresented his or her physical or mental health, or, alternatively on the theory that the defrauding party misrepresented his or her character, or past life in general.²¹²

207. All states ban marriage between siblings, between parent and child, and between parents and grandchildren. See generally Bratt, *Incest Statutes and the Fundamental Right of Marriage: Is Oedipus Free to Marry?*, 18 FAM. L.Q. 257 (1984); Thurman, *Incest and Ethics: Confidentiality's Severest Test*, 61 DEN. L.J. 619 (1984). There is some constitutional limit upon state's regulation of affinity relationships. See *Israel v. Allen*, 577 P.2d 762 (Colo. 1978) (court found unconstitutional state statute that prohibited marriage between adopted brother and sister).

208. See Wardle, *Rethinking Marital Age Restrictions*, 22 J. FAM. L. 1 (1983-84). See also *Moe v. Dinkins*, 669 F.2d 67 (2d Cir. 1982) (underage plaintiffs not allowed to marry without consent of parents).

209. Some states expressly state that marriage is to be between persons of the opposite sex. See, e.g., MD. FAM. LAW CODE ANN. § 2-201 (1984) ("Only a marriage between a man and a woman is valid in this State."); TEX. FAM. CODE ANN. § 1.01 (Vernon 1985) ("A license may not be issued for the marriage of persons of the same sex.").

210. Even before no-fault divorce was enacted by the legislature, the California Governor's Commission on the Family in its 1966 report recommended the elimination of annulment in limited situations. As divorce becomes easier to obtain, annulment is not a significant means to dissolve a marriage. H. CLARK, *THE LAW OF DOMESTIC RELATIONS IN THE UNITED STATES* 127 (2d ed. 1988) (annulment used in only three percent of marriage dissolutions even in 1950).

211. *Id.* at 105. Even where there is no statutory authority, courts can set a marriage aside on the basis of equity and contract principles. Some states also allow for divorce based on fraud. See, e.g., CONN. GEN. STAT. ANN. § 466-40(c)(4) (West 1986).

212. For a more complete perspective on these and other elements of

With respect to whether nondisclosure constitutes a misrepresentation of physical or mental health, the medical evidence associated with AIDS certainly reveals that it is material. AIDS can be transmitted in sexual intercourse associated with marriage and the present prognosis is that every person infected with the virus will eventually develop symptoms and then die from the disease.²¹³ To withhold information concerning HIV infection at the time of marriage is certainly a material misrepresentation. Furthermore, because the disease promises to increase in voracity, judicial sentiment will likely be more than eager to allow annulment upon petition of an "unknowing spouse" only recently discovering the other's infection.

Any reluctance on the court's part in granting the annulment will likely be grounded on the traditional "prerequisite" that the party seeking the annulment must have made some sort of premarital inquiry.²¹⁴ Whether such inquiries are justified today in reference to AIDS is still an open question. However, present efforts by the states to conduct premarital HIV testing or to encourage couples to take the tests voluntarily would meet this objective.²¹⁵ An increasing number of states debate this issue and, according to Charles Cooper, former Assistant Attorney General, "[t]esting marriage license applicants is obviously one of the first places to start routine AIDS testing, because many such applicants already have their blood tested for venereal disease."²¹⁶ Such mandatory testing is likely to become the rule unless there are successful constitutional objections.²¹⁷

fraud, see *Reynolds v. Reynolds*, 85 Mass. (3 Allen) 605 (1862). See also H. CLARK, *supra* note 210, at 116-20 (misrepresentations of physical or mental health of one's character grounds for annulment).

213. As late as June 1988, researchers reported:

After studying a group of gay men from San Francisco for the past decade . . . researchers have produced a statistical model that predicts 99 percent of those infected will eventually develop [AIDS] if they do not die from other causes. Because no one has ever been cured of AIDS, a 99 percent AIDS rate means that virtually all would die unless a treatment is developed.

Wash. Post, June 3, 1988, at A1, col. 4.

214. See H. CLARK, *supra* note 210, at 116.

215. At present Illinois has mandatory premarital testing for AIDS. ILL. ANN. STAT. ch. 40, para. 204(b) (Smith-Hurd Supp. 1988). Texas has also passed a statute mandating the test when prevalence in the state reaches a designated point. This point has not yet been reached. TEX. REV. CIV. STAT. ANN. art. 4419b-1 § 9.02(e) (Vernon Supp. 1989). The following states have also introduced legislation requiring testing for the virus prior to marriage: Alabama, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia (at present sends AIDS information to all applicants for a marriage license) and Washington. See SYNOPSIS, *supra* note 125, at 64-77.

216. Cooper, *supra* note 103, at 1, 7.

217. See Jones, *The Rights to Marry and Divorce: A New Look at Some Unan-*

Even if testing is not mandated by statute, it is doubtful if the states would require the annulment petitioner to have made any concrete effort to determine infection with AIDS. The nature of the disease and the fatal consequences make it likely that mere HIV positivity would balance the equities in favor of the petitioner and against the respondent seeking to maintain the marriage.

The situation might be somewhat different when the petition for an annulment is based on fraud arising from the misrepresentation of character or past life in general. However, when AIDS is involved, it is likely that the result will be the same: annulment granted. Many annulments have been granted based on this type of misrepresentation.²¹⁸ The AIDS issue may not be involved directly, but it is present when the respondent in a petition for an annulment was involved in high risk activities such as homosexuality,²¹⁹ use of narcotics,²²⁰ and especially when the marriage has never been consummated or the petitioner is a woman, or very young.²²¹

Although the granting of an annulment means that a marriage never existed, this fact is probably unimportant to most parties, who are only interested in their future status.²²² It is perhaps only with void grounds, which possess criminal penalties, that annulment retains its importance and distinctiveness. Yet, fraud is not included in these and fraud is likely to be the only link between annulment and the HIV virus. Fraud will be an option within the constraints listed and will have an impact on family law and AIDS.²²³

swered Questions, 63 WASH. U.L.Q. 577 (1985); Comment, *Califano v. Jobst, Zablocki v. Redhail, and the Fundamental Right to Marry*, 18 J. FAM. L. 587 (1979-80); Comment, *The Constitutional Implications of Mandatory Testing for Acquired Immunodeficiency Syndrome—AIDS*, 37 EMORY L.J. 217 (1988). See generally Hafen, *The Constitutional Status of Marriage, Kinship, and Sexual Privacy—Balancing the Individual and Social Interests*, 81 MICH. L. REV. 463, 507-11 (1983).

218. H. CLARK, *supra* note 210, at 119 (annulments granted on basis of misrepresentation concerning health).

219. *But see* Sampson v. Sampson, 332 Mich. 214, 50 N.W.2d 764 (1952) (raises question of effect of homosexuality); Santos v. Santos, 80 R.I. 5, 90 A.2d 771 (1952) (denying annulment on grounds wife was lesbian).

220. See, e.g., Costello v. Porzelt, 116 N.J. Super. 380, 282 A.2d 432 (1971). *But see* Husband v. Wife, 257 A.2d 765 (Del. Super. Ct. 1969) (wife concealed disabling use of drugs and court denied annulment because it did not involve essentials of marriage).

221. See Wolfe v. Wolfe, 76 Ill. 2d 92, 389 N.E.2d 1143 (1979) (annulment granted where wife falsely claimed first husband died); Wemple v. Wemple, 170 Minn. 305, 212 N.W. 808 (1927).

222. H. CLARK, *supra* note 210, at 133-34.

223. While fraud has been discussed here in reference to an annulment petition, it is also the basis for a cause of action in tort. The elements of misrepresentation or deceit are: (1) a false representation by the defendant, (2) the defendant's knowledge or belief of the falsity of the representation or the absence of any reasonable basis for the defendant to believe in its truth, (3) the defendant's intention to induce the plaintiff to act in reliance upon the representation, (4) the plaintiff's justifiable reliance upon the misrepresentation, and

B. *Infectious Diseases and Torts*

Even as AIDS poses new threats by establishing what has been described as a "family tree" of mutations, the fact still remains that, "[i]n most cases of AIDS in the United States, the virus appears to have been transmitted through one or more of four routes: sexual contact, intravenous drug administration with contaminated needles, administration of blood or blood products, and passage of the virus from infected mothers to their newborn."²²⁴ With each of the four methods of transmission there is, both within and without the family, the possibility that transmission of the disease will give rise to a civil cause of action in tort.²²⁵

Sexual contact covers a wide range of behavior, from homosexual activity to heterosexual intercourse between married persons, to pedophilia,²²⁶ to prostitution. Some of the sexual activity is in conjunction with the use of drugs or shared contaminated needles, but if we isolate those at risk simply because of sexual activity, we discover that sexual activity can certainly result in tortious behavior.

Today, perhaps the most flagrant example of negligent, perhaps criminal, conduct of a sexual nature is that of Gaetan Dumas, often referred to as Patient Zero. He was a handsome airlines steward who was one of the first to develop what would eventually be diagnosed as Kaposi sarcoma. The diagnosis occurred in 1980 and he died of AIDS in 1984, with yet another sexual partner on the way to spend a few days with him. The debate over the conduct of Gaetan Dumas centers on:

Whether Gaetan Dumas actually was the person who brought AIDS to North America remains a question of debate and is

(5) damage to the plaintiff resulting from the reliance. RESTATEMENT (SECOND) OF TORTS § 525 (1977).

224. Curran, Morgan, Hardy, Jaffe, Darrow & Dowdle, *The Epidemiology of AIDS: Current Status and Future Prospects*, 229 SCIENCE 1352, 1355 (1985). Even though recent reports have established a new strain of the virus, one that can kill by a mechanism completely different from the one the virus has been understood to use, the methods of transmitting the virus remain the same. *An AIDS Strain kills in Different Way*, Wash. Post, June 10, 1988, at A4, col. 4.

225. BLACK'S LAW DICTIONARY 1335 (5th ed. 1951). Three elements of every tort action are: existence of a legal duty from defendant to plaintiff, breach of duty, and damages as a proximate result. *Id.*

226. The varieties of sexual assault that could include minors were described in the Watkins Report:

In 1985, the FBI recorded 87,340 rapes in the United States, or approximately 239 rapes per day. This greatly underestimates the true scope of rape since it includes only female victims 16 years and older and only instances that were reported to police. Government estimates suggest that for every rape reported to police, 3-10 rapes are not reported. Rape is still one of the most underreported crimes. In addition, the American Humane Association estimates that 110,878 children were reported as victims of sexual maltreatment in 1984, a 54 percent increase from 1983.

WATKINS REPORT, *supra* note 118, at 219.

ultimately unanswerable. The fact that the first cases in both New York City and Los Angeles could be linked to Gaetan, who himself was one of the first half-dozen or so patients on the continent, gives weight to that theory. Gaetan traveled frequently to France, the western nation where the disease was most widespread before 1980. In any event there's no doubt that Gaetan played a key role in spreading the new virus from one end of the United States to the other.²²⁷

But there is no debate as to Gaetan's conduct right up to the moment of his death. He continued to have multiple and random sexual partners, living a code of conduct that held: "It's my right to do what I want to do with my own body."²²⁸ Describing a scene in a San Francisco bathhouse, a place where men from all over the country came for sex and which has now voluntarily closed, Randy Shilts captures a scene from Gaetan's life two years *after* he was diagnosed:

Back in the bathhouse, when the moaning stopped, the young man rolled over on his back for a cigarette. Gaetan Dumas reached up for the lights, turning up the rheostat slowly so his partner's eyes would have time to adjust. He then made a point of eyeing the purple lesions on his chest. "Gay cancer," he said, almost as if he were talking to himself. "Maybe you'll get it too."²²⁹

It is this type of intentional and reckless activity which prompted the Presidential Commission to recommend:

Adoption by the states of a criminal statute directed to those who knowingly engage in behaviors which are, according to the scientific research, likely to result in transmission of HIV, clearly setting forth those specific behaviors subject to criminal sanctions. With regard to sexual transmission, the statute should impose on HIV-infected individuals who know of their condition to sexual partners, to obtain their partners' knowing consent, and to use precautions, punishing only for failure to comply with these affirmative duties.²³⁰

In that such a statute places a duty to disclose upon the infected person, the analysis pertaining to reporting statutes and the child abuse statutes becomes pertinent.²³¹ There will also be questions concerning

227. R. SHILTS, *supra* note 4, at 439.

228. *Id.* at 200.

229. *Id.* at 198.

230. WATKINS REPORT, *supra* note 118, at 218. The Report also recommends that prostitution laws be strictly enforced. *Id.* Even prior to the report, 15 states introduced legislation declaring various aspects of HIV transmission criminal. SYNOPSIS, *supra* note 125, at 28-32.

231. See H. CLARK, *supra* note 210, at 347-50. The central issue vis-a-vis the

the relationship between violations of such criminal statutes and civil liability, that is, whether a violation of the criminal law constitutes negligence per se. Additionally, with respect to doctors, the question will arise as to whether there will be a continuing duty to report in order to avoid criminal and civil penalties.²³²

Civil liability for infecting another with disease is comparable to common law transmission of infectious disease.²³³ Of course, the presence of venereal disease has long been the subject of family law regulation. Physicians had to certify that couples were free of disease before a license could be issued; there were criminal penalties if a person married knowing he or she had the disease; presence of a disease was a ground for annulment; in some cases the marriage is void from the start.²³⁴ Any analysis of tort responsibility should begin with transmission of an infectious disease, but the civil responsibility could also include causes of action based on battery,²³⁵ negligence,²³⁶ or the fraud and deceit suits as discussed earlier.

statute and negligence concerns negligence per se and any civil liability that results as a consequence of the criminal statute. *See* W. PROSSER & R. KEETON, *supra* note 113, at 220-34. Also, some states include a specific provision for civil liability for failure to report. *See* ARK. STAT. ANN. § 12-12-503 (b) (1987) (wilful failure to report actionable); COLO. REV. STAT. § 19-10-104(4)(b) (1986) (wilful violation of reporting law actionable); IOWA CODE ANN. § 232.75(2) (West 1985) (knowing failure to report actionable); MICH. COMP. LAWS ANN. § 25.248(13)(1) (West Supp. 1988) (civil liability for failure to report).

232. *See* Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (psychotherapist liable for failure to use reasonable care in protecting known victim of patient); Landeros v. Flood, 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976) (court allows a physician to be sued when he negligently failed to diagnose and report child abuse).

233. *See generally* R. O'BRIEN, *supra* note 48, at 149-64; Sarno, *Tort Liability for Infliction of Venereal Disease*, 40 A.L.R.4th 1089 (1985).

234. When referring to statutes requiring testing for venereal disease, Professor Clark states that "the only reported case dealing with the constitutionality of these statutes has held them valid, *undoubtedly a sound result*." H. Clark, *supra* note 210, at 99 (emphasis added) (citing Peterson v. Widule, 157 Wis. 641, 147 N.W. 966 (1914)). For state statutes declaring a marriage void, *see* DEL. CODE ANN. tit. 13, § 1.01(b)(3) (1981) (marriage prohibited and void from time its nullity is declared where either party is "venereally diseased or is suffering from some other communicable disease, the nature of which is unknown to the other party"); MICH. COMP. LAWS ANN. § 551.6 (West 1984) (no person afflicted with syphilis or gonorrhea shall be capable of marrying); NEB. REV. STAT. § 42-102 (1984) (no person afflicted with venereal disease may marry).

235. Battery is defined at common law as the intentional, harmful or offensive and unprivileged contact with the person of another. RESTATEMENT (SECOND) OF TORTS §§ 13, 18 (1965). Note that because of contact and intent it may have criminal penalties as well. *See* W. PROSSER & R. KEETON, *supra* note 113, at 33-39 (discussing intent).

236. Negligence is conduct that is less than that standard established by law for the protection of others against the unreasonable risk of harm. RESTATEMENT (SECOND) OF TORTS § 282 (1965). If a person is living within a risk category and aware of the nature of HIV transmission, is it not reasonable to expect him or her to be tested to ascertain transmission status?

Between unmarried persons, tort claims would proceed in accordance with established grounds and defenses. Possible defenses would include consent,²³⁷ the fact that transmission occurred through an illegal act such as fornication, adultery or sodomy,²³⁸ that the suit constituted an invasion of privacy,²³⁹ or that the statute of limitations had run. In addition to these legal defenses, fear, discrimination, the lengthy incubation period of the disease—now estimated to be as long as 15 years in some persons—and the inability to collect any judgment against a tortfeasor, all serve as *de facto* defenses to potential lawsuits.

A married person's right to sue a spouse will most likely parallel an unmarried person's right to sue. Interspousal immunity, once so favored because of the technical unity of husband and wife, is being abolished.²⁴⁰ In addition to these "classic" lawsuits, AIDS will probably cause an increase in all types of litigation regardless of how tenuous the AIDS connection may be.²⁴¹ Moreover, newer causes of action such as "wrongful life" are gaining judicial acceptance.²⁴²

It is doubtful that AIDS will have an impact on the tort suits arising

237. *Oberlin v. Upson*, 84 Ohio St. 111, 116-17, 95 N.E. 511, 512 (1911). Perhaps doctrines such as comparative negligence or contributory negligence may also apply.

238. See, e.g., *Deeds v. Strode*, 6 Idaho 517, 55 P. 656 (1898) (transmission of gonorrhea during invalid marriage not actionable injury). See also *Bowers v. Hardwick*, 478 U.S. 186 (1986) (no Constitutional right to practice sodomy).

239. See Note, *The Supreme Court Refused to Expand the Right of Privacy to Include Homosexual Sodomy* in *Bowers v. Hardwick*, 14 PEPPERDINE L. REV. 313 (1986). See also *Kathleen K. v. Robert B.*, 150 Cal. App. 3d 992, 998 Cal. Rptr. 273 (1984); *Barbara A. v. John G.*, 145 Cal. App. 3d 369, 193 Cal. Rptr. 422 (1983).

240. See H. CLARK, *supra* note 210, at 370-74 (author cites the absence of any realistic policy basis for interspousal immunity in torts). For an examination of parental immunity and its gradual abolition, see Note, *Rousey v. Rousey: The District of Columbia Joins the National Trend Towards Abolition of Parental Immunity*, 37 CATH. U.L. REV. 767 (1988).

241. Insurance companies seek to limit coverage under their policies with a clause that specifically excludes venereal disease or one that excludes members of the family residing in the same household as the insured. There is at least one commentator who argues that such clauses violate public policy. See Ashdown, *Intra-family Immunity, Pure Compensation, and the Family Exclusion Clause*, 60 IOWA L. REV. 239 (1974). With increasing numbers of persons living in family-type arrangements without the legal status of family, the clauses would need to be drafted more carefully to exclude many persons at risk today. See Wehrwin, *Homeowner Policy Pays Herpes Claim*, NAT'L L.J., July 15, 1985, at 3 (suggesting policies may be rewritten to exclude coverage for herpes and AIDS).

242. Two recent California cases have recognized a "wrongful life" action, establishing an important precedent for the argument that when an individual or an institution fails to warn parents that a child may be born with birth defects, the parents are thus improperly denied the opportunity to avoid conception or to terminate pregnancy. See *Curlender v. Bio-Science Labs.*, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980) (child could recover for Tay-Sachs because of negligence of laboratory in testing for Tay-Sachs when parents went to laboratory with that particular purpose in mind); *Turpin v. Sortini*, 31 Cal. 3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982) (narrowed *Curlender* to allow recovery of special damages for the extraordinary expenses necessary to treat the hereditary

out of infectious disease transmission through narcotics. While it is true that, "[i]noculation of HIV intravenously appears to be an efficient means of transmissions,"²⁴³ persons within this category form a unique portion of the population. As described by Admiral Watkins in his report:

Patient care in active drug abusers is principally complicated by the non-compliance and the unreliability of this patient group. There is no certainty that medications are taken, and follow-up is frequently poor. There are usually many other co-factors present which make their prognosis particularly poor. . . . Treatment settings are often emergency rooms, and opportunities for long-term care intervention are limited. In this context, treatment may be less than aggressive or complete, contributing to shorter survival.²⁴⁴

Perhaps in reference to class-action suits or litigation involving third party litigants,²⁴⁵ there may be litigation in reference to narcotics abusers.²⁴⁶

Extensive litigation has arisen as a result of blood product contamination.²⁴⁷ There is little likelihood that the amount of such litigation will decrease without the intervention of statutes directly precluding suits or limiting recovery. The Watkin's Report indicates that, as of May 6, 1988, "2,242 of the people diagnosed with AIDS had acquired the infection through the transfusion of blood, blood products, or the clotting factors used to treat hemophilia."²⁴⁸ Testimony before the Presidential Commission led Admiral Watkins to write that "[t]he initial response of the nation's blood banking industry to the possibility of contamination of the nation's blood by a new infectious agent was, in retro-

disease). For a general discussion of these issues, see *infra* notes 294-330 and accompanying text.

243. Francis & Chin, *The Prevention of Acquired Immunodeficiency Syndrome in the United States*, 257 J. A.M.A. 1357, 1358 (1987).

244. WATKINS REPORT, *supra* note 118, at 25.

245. See *Jaffee v. Dills*, No. 84 CI-02139, slip op. (Ky. Ct. App. 1984) (husband filed suit against wife's lover when wife received herpes from lover and wife then transmitted it to husband).

246. Not included in this group are those who become infected in the health care settings. See R. O'BRIEN, *supra* note 48, at 149-63.

247. See generally *Liability Suit Barred by 'Blood Shield' Law*, AIDS Pol'y & Law (BNA) at 2-3 (Jan. 28, 1987); *Suit Against Blood Bank Amended to Include Suicide*, AIDS Pol'y & Law (BNA) at 3 (Jan. 14, 1987); *The Initial Impact of AIDS on Public Health Law in the United States—1986*, 257 J. A.M.A. 344, 346 (1987). According to Duncan Barr, a trial attorney in San Francisco, the total number of lawsuits brought by May 11, 1987, against all manufacturers of anti-hemophilic factor used by hemophiliacs totals only 26. But the total number of lawsuits against all blood banks in the United States arising out of transfusions is over 100. Barr, *AIDS Transfusion Litigation*, reprinted in *AIDS: A Litigation Challenge Searching for Solutions*, 1987 A.B.A. SEC. LIT. REP. 83, 83.

248. WATKINS REPORT, *supra* note 118, at 121.

spect, unnecessarily slow.”²⁴⁹ To address this, the Chairman makes recommendations concerning what should be done to warn past blood recipients and to maintain a safe blood and organ supply.²⁵⁰

During the legislative year 1987, twenty-two states introduced legislation concerning blood and body parts.²⁵¹ Most of the statutes introduced allow family members to donate blood, for the patient himself or herself to donate blood, or prohibit testing of blood for the AIDS virus without the consent of the donor. Some states, including Maryland, New Mexico and New York, specifically sought to provide exemption from liability.²⁵² However, there is little doubt the blood-related litigation will continue for the next few years. Furthermore, because so many persons received blood products before there was an adequate and reliable testing procedure,²⁵³ there is a definite need to “lookback” on transfusion recipients.²⁵⁴ Because of the fear and possible transmission of the virus by unsuspecting persons, and the immense financial burdens involved, it is “essential that some sort of national system for compensating individuals who contracted AIDS through transfusions prior to June 1985 when anti-HIV testing was unavailable, be instituted by the federal government.”²⁵⁵

Finally, law suits are likely to develop because of the transmission of HIV by mothers into their children. One author has noted that “[t]ransmission from infected mothers to their infants can apparently occur in utero, during parturition, or during postpartum breast-feeding.”²⁵⁶ As with persons who abuse narcotics and share contaminated needles, there may be an absence of litigation because of societal factors, but there is little doubt that the potential for such tort suits is present.

According to the National Commission on Infant Mortality, there will be an estimated 10,000 to 20,000 cases of pediatric AIDS in the United States by 1991.²⁵⁷ Most of these cases (77%) are a result of perinatal transmission from infected mothers and usually the infant is the

249. *Id.*

250. *Id.* at 123-25.

251. SYNOPSIS, *supra* note 125, at 3-11.

252. *Id.*

253. See R. SHILTS, *supra* note 4, at 539.

254. According to Duncan Barr, the major goals of a “lookback” program are: “following up on transfusion recipients from donors who subsequently develop AIDS from unknown sources; following up on donors when a transfusion recipient develops AIDS from unknown sources; following up on donors who test positive for HIV; and following up on transfusion recipients from donors later testing positive for the AIDS virus.” Barr, *supra* note 247, at 84. See also Klein & Alter, *Blood Transfusion and AIDS*, reprinted in AM. MED. A., INFORMATION ON AIDS FOR THE PRACTICING PHYSICIAN, July 1987, at 7, 8-9.

255. *Survey*, *supra* note 80, at 4.

256. Francis & Chin, *supra* note 243, at 1358 (footnotes omitted).

257. WATKINS REPORT, *supra* note 118, at 17.

first member of the family to be diagnosed. The Watkins Report notes that "[a]n HIV-infected mother, usually a drug user or the sex partner of an HIV-infected individual, will transmit the virus to her newborn in 20 percent to 60 percent of infected pregnancies."²⁵⁸ Even more distressing is the Commission's finding that: "[f]our to five percent of pregnant women in some inner city clinics are currently infected. As many as 4,000 babies will be born with HIV infection in the U.S. in 1988. Currently, one in every 61 babies born in New York City is seropositive."²⁵⁹

The magnitude of this problem will certainly be highlighted by the cases that reach the courts asserting civil responsibility against the father or mother, on theories that include "wrongful life," child abuse in gestation, and negligent transmission of a contagious disease to an unborn child.²⁶⁰ The current abolition of the parent-child immunity doctrines²⁶¹ and the public sentiment to make mothers accountable for the possible harm to children through voluntary testing, indicate that governments will become more active in the promotion of sexual precautions, if not total abstinence.²⁶²

C. Divorce and Support

Just as fraud, duress, and venereal disease are likely to affect the once moribund state of voidable annulments in the United States, so is it possible that AIDS will resurrect fault and hidden agendas in divorce. Recently, *The New York Times* published an article that described this phenomenon entitled: *AIDS and Divorce: A New Legal Arena*.²⁶³ The article described the effect of AIDS upon divorce litigation, especially in California and New York, as including the following:

- (1) The disease is reviving the old concept of fault: Who did what to whom?
- (2) Spouses are being advised by attorneys not to divorce and

258. *Id.* at 17-18.

259. *Id.* at 18.

260. See generally Robertson, *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injuries and Wrongful Life*, 1978 DUKE L.J. 1401. The current furor over child abuse has also prompted courts and legislatures to contemplate abuse in gestation as a crime. See O'Brien, *Pedophilia: Legal Predicament of Clergy*, 4 J. CONTEMP. HEALTH L. & POL'Y 91, 100-08 (1988).

261. See Beal, "Can I Sue Mommy?" *An Analysis of a Women's Tort Liability for Prenatal Injuries to Her Child Born Alive*, 21 SAN DIEGO L. REV. 325 (1984); Comment, *Child v. Parent: Erosion of the Immunity Rule*, 19 HASTINGS L.J. 201 (1967); Comment, *Tort Actions Between Members of the Family—Husband & Wife—Parent & Child*, 26 MO. L. REV. 152, 180-217 (1961).

262. As an example of the federal government's current approach towards education, see *Condoms for Prevention of Sexually Transmitted Diseases*, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 133, 133-37 (1988) (condoms, if effective at all in preventing transmission of the disease, will also prevent conception); *Understanding AIDS*, *supra* note 74, at 261-69.

263. N.Y. Times, Sept. 21, 1987, at B17, col. 2.

share the estate when he or she could wait a year or so and inherit everything upon death.

(3) There is revival of the detective monitoring extra-marital affairs, especially watchful for bisexuality. Until recently, following no-fault legislation, the detectives searched for hidden assets.

(4) "Concern about this disease and its long range consequences is making women nuts and making lawyers nuts."²⁶⁴

At present, there is no legal pattern established through court divorce cases or new statutory enactments. Consequently, this is an area of much speculation and debate.²⁶⁵ The one fact that has established itself is the fear of the disease may produce an increasing number of divorce cases.

To date, AIDS still has not made a significant impact upon the heterosexual community. The Centers for Disease Control reports as of April 27, 1987, that "a total of 682 cases (1.9% of all reported cases) have been attributed to heterosexual contact with an individual with AIDS or at risk for AIDS."²⁶⁶ In a recent report, 97 female sexual partners of 93 men infected with HIV were studied. All of the women had sexual contact within the year before their partner had been diagnosed as having AIDS, or was found to have a positive reaction to an approved test. Fifty-seven percent (57%) of the women had partners who described themselves as bisexual. Overall, 23% of the women were infected at the end of the study.²⁶⁷ The report went on to state that:

[t]he total number of exposures to the index (sexual contacts with ejaculation) and the specific practice of anal intercourse, also with the infected partner, were associated with transmission. Neither condom use, total number of sexual partners since 1978, nor lifetime number of other sexually transmitted diseases was associated with infection.²⁶⁸

264. *Id.*

265. *See id.* (attorney perspectives on AIDS as fault ground for divorce).

266. CDC AIDS WEEKLY SURVEILLANCE REP., Apr. 27, 1987, at 1-5. This lack of greater heterosexual infection remains a constant and somewhat baffling aspect of the AIDS crisis. For a discussion of this mystery, see *supra* notes 17-25, and accompanying text. *See also Trends in Human Immunodeficiency Virus Infection Among Civilian Applicants for Military Service—United States, October 1985-March 1988*, 37 CDC MORBIDITY & MORTALITY WEEKLY REP. 677 (1988).

267. Padian, Marquis, Francis, Anderson, Rutherford, O'Malley & Winkelstein, *Male-to-Female Transmission of the Human Immunodeficiency Virus*, 258 J. A.M.A. 788, 788 (1987).

268. *Id.* In its conclusion the study admits that the data still provide no certainty concerning infection of females through sexual contact with high-risk men. It further notes that "HIV infection is extending from high-risk men to heterosexual women. However, the actual numbers of women infected by high risk men remains undetermined." *Id.* at 790.

Thus, more than anything else, fear of the disease is likely to be the essence of the divorce suits brought by heterosexual spouses. The existing laws of the states providing for divorce will allow this fear to be translated into any of the existing grounds available to dissolve the marriage. Adultery, a traditional common law ground and available in more than half of the states, would include a sexual act with a person of the same sex or with a prostitute or person of the opposite sex who may be infected with the disease.²⁶⁹ Desertion is also a traditional fault ground and available in twenty-nine states, but here, because of the characteristics of the ground, constructive desertion is likely to be the basis of the suit.²⁷⁰ This would occur through the departure from the home of a spouse who asserts that he or she can no longer live in the home because of the infection with HIV or the diagnosis of symptoms of the remaining spouse. Thus, AIDS would justify the departure of the spouse and give that *departing* spouse cause to end the marriage.²⁷¹ Finally, cruelty may also be asserted because, "the conduct of the defendant so endangers the physical or mental well being of the plaintiff as renders it unsafe or improper for the plaintiff to cohabit with the defendant."²⁷² Cruelty will generally be asserted as a ground when the statute permits dissolution on account of "great mental distress."²⁷³

The use of fault grounds has been diminishing since the advent of no-fault legislation in the late 1960's.²⁷⁴ Prior to "no fault," adultery accounted for approximately three percent of all divorces, and desertion accounted for only eighteen percent. Cruelty, however, because the definition could be molded to the facts, accounted for 50% to 60% of all

269. For a standard definition of adultery, see N.Y. DOM. REL. LAW § 170 (McKinney 1977) (includes deviant sexual intercourse in the definition). *See also* Owens v. Owens, 247 Ga. 139, 274 S.E.2d 484 (1981) (extramarital homosexual relations constitute adultery).

270. *See generally* Note, *Constructive Desertion—A Broader Basis for Breaking the Bond*, 51 IOWA L. REV. 108 (1965); Note, *Constructive Desertion as a Ground for Divorce in Virginia*, 47 VA. L. REV. 362 (1961).

271. The availability of constructive desertion would depend upon the court's recognition that seropositivity or AIDS justifies the infection-free spouse leaving the home. This is the nexus with fear of the disease and it is probable that the court would base any divorce action on another, more statutory, ground.

272. N.Y. DOM. REL. LAW § 170(1) (McKinney 1977). *Cf.* GA. CODE ANN. § 19-5-3 (1982) (defining cruelty as "willful infliction of pain"). *See also* Beaver v. Beaver, 313 Pa. Super. 512, 516, 460 A.2d 305, 307 (1983) ("indignities may consist of vulgarities, unmerited reproach, habitual contumely, studied neglect, intentional incivility, manifest disdain, abusive language, or malignant ridicule"); Goodhart, *Cruelty, Desertion and Insanity in Matrimonial Law*, 79 L.Q. REV. 98 (1963).

273. UTAH CODE ANN. § 30-3-1(3)(g) (1984) (cruel treatment to the extent of causing bodily injury or great mental distress). Incorporated within this would be "apprehension of danger to life, limb or health." *See* GA. CODE ANN. § 19-5-3 (Supp. 1986).

274. *See* R. O'BRIEN, *supra* note 48, at 111-13.

cases.²⁷⁵ Today, after no-fault, approximately twenty states have retained some traditional fault grounds, either alone, or in conjunction with no-fault grounds.²⁷⁶ However, all American jurisdictions now have some form of no-fault divorce such as irretrievable marital breakdown, irreconcilable differences, living separate and apart, or incompatibility.²⁷⁷ The trend is towards the use of one of these no-fault grounds with the central issue being the division of property. But fear associated with AIDS and HIV infection may have an impact causing spouses to petition the court for a divorce on the basis of a fault ground, rather than no-fault. Money, property, and AIDS as a manifestation of improper conduct will form the parameters of the fault divorce.

For instance, the trend has been to minimize the importance of marital misconduct as a factor in the distribution of property, seeking instead to divide the property in accordance with more objective factors.²⁷⁸ Yet, the presence of AIDS and the social stigma it entails—not to mention the certain dissipation of economic resources—raises the possibility that this trend may halt and reverse to a point where the marital fault, dissipation of mutual funds, or economic misconduct will form a stable ingredient in any discretionary distribution of assets. That would be a regrettable development. If the facts are examined, it will certainly be discovered that the person most affected by denial of alimony due to fault or misconduct is the woman, often the spouse least able to find just and dignified employment. In addition to equitable arguments, an equal protection argument can also be raised. Furthermore, scholars such as Professor Homer H. Clark, Jr., are correct in their observations that: "Since facile judgments about who is responsible for the breakup of a marriage are notoriously unreliable, basing alimony awards upon marital fault risks being guided by nothing more substantial than prejudice or sentimentality. . . . [excluding] fault as a consideration in the alimony decision therefore reflect[s] the more sensible policy."²⁷⁹

Much will depend upon whether the particular state statutes allow fault or dissipation to become a factor in property distribution. For instance, Virginia allows the court to consider conduct of the parties that

275. D. JACOBSON, *AMERICAN MARRIAGE AND DIVORCE* 122, 124 (1959). Remember that some states (New York, for example) formerly relied heavily on annulment to terminate marriages.

276. Freed & Walker, *Family Law in the Fifty States: An Overview*, 21 *FAM. L.Q.* 417, 441-42 (1988).

277. *Id.* A small but growing number of states allow for a "paper" dissolution by a form of affidavit procedure where there is mutual consent to the divorce. Some states allow for a summary dissolution for short marriages with no children, no maintenance request, and agreement as to division of property. *Id.* at 442-43.

278. *Id.* at 465-66.

279. H. CLARK, *supra* note 210, at 643.

brought about the end of the marriage in dividing property.²⁸⁰ This position was emphatically reiterated in a recent Virginia case.²⁸¹ On the other side, there are those who promote the total abolition of alimony, or at least a drastic change in the way alimony is distributed by the nation's courts today.²⁸² Between the two extremes are the trial courts which have—unless specifically restricted by statute—wide discretion in determining the amount and propriety of alimony.²⁸³ The issue of the 1990's seems to be the extent to which trial courts and state legislatures exercise their discretion in allowing fault and marital misconduct to affect alimony awards and property distribution.

IV. CHILDREN'S ISSUES: FEAR OF THE UNKNOWN

A. *How Do You Count Children?*²⁸⁴

Perhaps because AIDS was initially—albeit erroneously—considered a homosexual disease, the thought that children would somehow become infected and then develop symptoms was far from the national consciousness. Looking back, however, it is safe to assume that children (especially infants) have had the disease, but their deaths were never reported as such. Today, the CDC's expanded definition of AIDS confirms the devastation the disease is causing among children.²⁸⁵

280. VA. CODE ANN. § 20-107.3(E)(5) (1986). There are 17 states and the Virgin Islands that specifically exclude fault as a factor in distribution and/or maintenance of property; 10 of these nonetheless allow economic misconduct to be considered; 10 states remain silent as to fault. Freed & Walker, *supra* note 276, at 462-63.

281. Bacon v. Bacon, 3 Va. App. 484, 351 S.E.2d 37 (1986). See also Routhier v. Routhier, 128 N.H. 439, 514 A.2d 825 (1986) (defendant's fault one of several elements in justifying unequal distribution of property); Rosenberg v. Rosenberg, 126 A.D.2d 537, 510 N.Y.S.2d 659 (1987) (fault must be egregious or uncivilized); Erickson v. Erickson, 384 N.W.2d 659 (N.D. 1986); Conley v. Conley, 508 A.2d 676 (R.I. 1986) (fault an element in state statute); Rafidi v. Rafidi, 718 S.W.2d 43 (Tex. Ct. App. 1986) (fraudulently concealing assets, in community property state is basis for disproportionate division of assets).

282. See UNIF. MARRIAGE AND DIVORCE ACT § 308(a), 9A U.L.A. 160 (1979); R. LEVY, UNIFORM MARRIAGE AND DIVORCE LEGISLATION: A PRELIMINARY ANALYSIS 144-50 (1969). See also Weitzman, *The Economics of Divorce: Social and Economic Consequences of Property, Alimony and Child Support Awards*, 28 UCLA L. REV. 1181, 1188-96 (1981).

283. For supporting cases, see H. CLARK, *supra* note 210, at 644 n.33.

284. The Watkins Report notes that it is difficult to adequately describe a population as complex as the United States and that "[t]he research community should be actively engaged in developing innovative models that better describe and explain the transmission of HIV within the population." WATKINS REPORT, *supra* note 118, at 9. The suggestion is made here that those children defined for government purposes as poor or homeless should be targeted as a model for extensive studies regarding transmission, progression and infectivity. As a model report, see L. SCHOOR, WITHIN OUR REACH (1988) (describing social programs that have brought about satisfactory results).

285. R. SHILTS, *supra* note 4, at 458. The Watkins Report notes that "[t]he case definition of AIDS has undergone [extensive] revisions, and in September

With children the problem of diagnosis is particularly difficult. Since the cause of death will often be a symptom such as pneumonia or other opportunistic infection or malignancy, methods by which the disease is usually identified in the child will not be accurate. With the exception of those cases which can be traced to hemophilia or blood transfusions,²⁸⁶ the vast majority of cases of children with AIDS can be counted as "born in poverty." Furthermore, as the blood supply becomes safer, the children who run the greatest risk of contracting the virus will be those born into poverty and into communities where sharing of contaminated needles is commonplace, and perinatal infection is rampant.

For the most part, children who are hemophiliacs or those who acquired the disease through a blood transfusion or organ donation, are older and born into a family with greater resources than those who acquire the disease perinatally. These older children suffer unique burdens of discrimination and a severe altering of previously normal lives. A great economic burden is placed on the parents and the community is alarmed at the prospect of having these children in school or even playing on the block. But again, assuming the safety of the blood and tissue supply, and that the disease in the United States does not mutate into a form that will transform it into that which is found in Africa, the number of children acquiring the disease through tainted blood will decline and possibly be eliminated.²⁸⁷ This is not the predicted future for the homeless and the poor and the day is not far off when, assuming the trends discussed above, children with AIDS can be counted as poor children, in

1987, a new definition, expanded to include wasting syndrome and central nervous system manifestations, increased the number of reportable cases. WATKINS REPORT, *supra* note 118, at 2.

Randi Shilts reports on one physician's encounter with AIDS-infected children:

Ayre Rubinstein was treating 128 patients from the impoverished Bronx for what he considered to be AIDS. The CDC would count only between 10 and 15 percent of these cases as meeting the agency's requirements for such classification. When Rubinstein ran [HIV] tests, however, he found that all were infected with the AIDS agent. Such results sparked early calls for the CDC to expand its definition of AIDS.

R. SHILTS, *supra* note 4, at 458.

286. The Watkins Report notes that "[t]hirteen percent of the children with HIV infection in the United States acquired the virus by means of transfusion, and six percent are hemophiliacs." WATKINS REPORT, *supra* note 118, at 19.

287. Not much is written about adolescents and AIDS, but it is reasonable to expect that poverty will be the associating factor in acquiring the disease with this group as well. Present data does indicate that adolescents have a higher rate of heterosexual transmission (perhaps because of carelessness or ignorance of transmission methods), a higher percentage of asymptomatic cases (but will develop symptoms as adults), a higher percentage of black and Hispanic AIDS cases (reference to possible link to poverty), lesser degree of access to legal services to protect rights of privacy, and fewer health services and programs. *Id.* at 19-20.

poor single parent households, infected perinatally, and dead by the age of three.

Jonathan Kozol, author of *Illiterate America* and frequent commentator on children's issues, recently wrote a book on poverty and homelessness. Reference has been made to these two factors before,²⁸⁸ but now they should be read within the dilemma of AIDS and children. The statistics indicate that these children are most at risk because of present infectivity, societal conditions that prompt transmission, and the progression of the disease within these poor-homeless enclaves. These conditions are described in Mr. Kozol's most recent book, *Rachael and Her Children*:

Knowingly or not, we are creating a diseased, distorted, undereducated and malnourished generation of small children who, without dramatic intervention on a scale for which the nation seems entirely unprepared, will grow into the certainty of unemployable adulthood. The drop-out rate for the poorest children of New York is 70 percent. For homeless kids the rate will be much higher. None of these kids will qualify for jobs available in 1989 or 1995. But everyone who is a female over twelve is qualified already to become a mother. Many only thirteen years of age in hotels like the Martinique [homeless shelter in New York City] are pregnant now. Hundreds more will have delivered children, brain damaged or not, before their sixteenth year of life. They will not be reading books about prenatal care. They will not be reading or observing warnings about damage done to infants by alcohol or drugs they may consume. When their hour of labor comes, many will not even understand the medical permission forms they sign before they are sent into anesthesia.²⁸⁹

This paragraph captures the essence of poor education, youth, disease, malnutrition, perinatal abuse, substance abuse, contaminated needles and places them within the context of the poor and homeless. But it omits two important elements: (1) the already existent contagiousness and infection and, (2) the connection with AIDS.

Unless someone has been more than casually involved with the homeless or those living in abject poverty, it is difficult to comprehend the level of infection and contagious illness already present in this population. In a confessional tone, Kozol writes that he always returned to his own hotel and steamed himself in a hot shower after visiting families

288. For a discussion of the continually changing American family, see *supra* notes 48-57 and accompanying text.

289. J. KOZOL, *supra* note 50, at 90. This alarm over homeless-poor children in America is shared by Senator Moynihan. See D. MOYNIHAN, *supra* note 51, at 105-94. The next stage is for more attention to be given to the link between these children and the threat of AIDS.

at New York welfare hotels.²⁹⁰ With high levels of infection and contagiousness already within the homeless-poor community, the added factor of AIDS will produce indescribable suffering and rapid opportunistic transmission of disease. This is the manner in which persons with AIDS gradually succumb to death. The Watkins Report notes that children with AIDS "are more susceptible than the general population to a wide range of malignancies."²⁹¹ Thus, while a person with a normal immune system might die of diseases that are normally associated with death such as cancer, persons with AIDS "get infections, opportunistic infections, only rarely seen in people with normal host responses."²⁹² They get critical and fatal infections from organisms that much of the normal population carries with immunity. These are very difficult infections to treat. They strike the patient suddenly and progress rapidly. Early and accurate therapy is essential, sometimes with drugs not immediately familiar or available to the general physician.²⁹³

Children who are homeless-poor should be counted as a special group and in special need of immediate attention as a distinctive element in the future of AIDS in the United States. This population most resembles the Third World, yet it exists—for the most part—within America's inner cities. As confirmed by the Watkin's Report, the numbers associated with these children testify to this:

Four to five percent of pregnant women in some inner city clinics are currently infected; currently one in every 61 babies born in New York is seropositive.

. . . .
Drug addicted seropositive babies are often born to mothers who had no prenatal care, and are often of low birth weight. . . . HIV-infected babies can also be born with other sexually transmitted diseases, such as congenital syphilis. . . .

. . . .
Most of these children die . . . before the age of three. A few have lived as long as nine years, but always with multiple and severe infections. . . .

. . . .
A higher percentage of black and Hispanic adolescents are seropositive than black and Hispanic adults; there is also a higher rate of heterosexual transmission among adolescents. As of January 1988, over 700 cases of AIDS were reported to the CDC in the 13 to 21 year age group, and that number is doubling each year. . . .

290. J. KOZOL, *supra* note 50, at 168.

291. WATKINS REPORT, *supra* note 118, at 14.

292. *Id.* at 15. The extreme cost of caring for these infected persons can be calculated in the billions of dollars.

293. *Id.*

...
Of all cases of AIDS in women, 51 percent are black and 20 percent are Hispanic. In all women, HIV infection occurs first through intravenous drug use, and second through heterosexual contact with an infected man. . . .

...
Black, Hispanic, Asians and Native Americans are the least likely to be the target of health education or service programs. Intravenous drug abusers constitute 25 percent of AIDS cases, but 70 percent of all heterosexually transmitted cases in native born citizens come from contact with this group. Also, 70 percent of perinatally infected children are the children of drug abusers or whose sexual partner was a drug abuser.²⁹⁴

These statistics provide the parameters for the issues surrounding children and AIDS. While most of the cases in the nation's family law courts will evolve around visitation rights and custody, the underlying problem of children will continue to grow at an alarming rate. The problem is that there is a segment of America's families defined as poor and often homeless, in which the AIDS virus is spreading with a voracious appetite.²⁹⁵

B. *Placement of Children*

The "problem" of AIDS has and will continue to surface in visitation and custody suits. As the number of parents who may be seropositive or who have specific AIDS symptoms increases, the courts are being asked to incorporate AIDS into already existing factors when making decisions about the best interest of the child. Sadly enough, the decisions are often affected by misinformation or veiled discrimination. But since custody and visitation concern the nuclear family and not strangers as with adoption or termination of parental rights,²⁹⁶ there is a lower legal standard of proof and certainly more discretion on the part of judges. Because this discretion can be abused, custody and visitation cases are subject to review by appellate courts. This has been done recently with AIDS.

294. WATKINS REPORT, *supra* note 118, at 143-44, 164-70, 195.

295. In 1981, when AIDS was just being discovered in the homosexual community, assurances were given that nobody need panic. R. SHILTS, *supra* note 4, at 107. The Watkins Report calls attention to the homeless-poor and recommends a course of action that should be followed today. WATKINS REPORT, *supra* note 118, at 164-70.

296. See R. O'BRIEN, *supra* note 48, at 121-23, 128-31. These pages set forth the issues in a manner consistent with current cases. With termination of parental rights based on HIV or AIDS, the legal threshold would be high, clear and convincing. See *Santosky v. Kramer*, 455 U.S. 745, 769 (1982) (state may terminate parental rights only when there is a showing of clear and convincing evidence).

In the summer of 1987, a New York court ruled that a father could not be denied visitation rights solely because he was diagnosed as having AIDS.²⁹⁷ The court took special note of current information regarding the disease and the manner in which it is transmitted and, as the father was involved in the health care field and was aware of the precautions, the court restored him to regularly scheduled unsupervised visitation rights. Likewise, on April 20, 1988, the Indiana Court of Appeals reversed a trial court's determination that a father's right to visit his child could be terminated because he was infected with the AIDS virus.²⁹⁸ The court, almost nineteen months after the initial custody award,²⁹⁹ took special notice of the visitation statute and a presumption favoring visitation that the proponent of termination must rebut. Also, as in New York, the court examined the medical evidence and concluded that AIDS is not transmitted through everyday household contact and thus the presumption in favor of the father visiting his child must be sustained.

These two cases exist within the public hysteria regarding AIDS³⁰⁰ but do not address the related discriminatory practices that surround similar issues. That is, while the courts may develop a strong negative response to discrimination based on AIDS, it is possible that this discrimination may then become more subtle, masking itself in more traditional forms such as gender,³⁰¹ race,³⁰² physical handicap, homosexuality,³⁰³ and other forms. As previously discussed with employment discrimination, decisions on the part of the judiciary may become more subtle as a result of societal standards, time constraints, and

297. *Jane W. v. John W.*, No. 35767/86, slip op. (N.Y. Sup. Ct. Aug. 21, 1987).

298. *Stewart v. Stewart*, 521 N.E.2d 956 (Ind. App. 1988).

299. For a discussion of discrimination and its impending problems, see *infra* notes 321-30 and accompanying text.

300. See Stone, *Protecting the Public from AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191 (1986); *Worry About Survival of Society First; Then AIDS Victims Rights*, Wash. Post, Sept. 8, 1985, at C1, col. 3 (discusses identifying and possibly segregating AIDS victims to protect general public); *Fear of AIDS Cited as Syphilis Rate Declines*, Wash. Post, Aug. 10, 1985, at A1, col. 2 (fear of AIDS causes sweeping changes in sexual activity).

301. See R. O'BRIEN, *supra* note 48, at 130 nn.125-26.

302. See *Jennings v. Jennings*, 490 So. 2d 10 (Ala. Civ. App. 1986) (fact that mother was dating man of another race not permissible consideration for denying her custody of minor child).

303. *Blank v. Blank*, 124 A.D.2d 1010, 509 N.Y.S.2d 217 (1986) (parent's infidelity or sexual indiscretions may only be considered if it can be shown that this will affect the child's welfare); *Anonymous v. Anonymous*, 120 A.D.2d 983, 503 N.Y.S.2d 466 (1986) (mother's sexual preference not permissible consideration without proof that child has been adversely affected). But see *Pascarella v. Pascarella*, 355 Pa. Super. 5, 512 A.2d 715 (1986) (burden on father to show that there would be no adverse effect upon children if they were exposed to his lifestyle and relationship he shared openly with male roommate).

the Solomonic difficulty of making a decision that will truly be in the best interest of the child.

In light of the two decided cases, attorneys, legislatures and judges would be advised to consult the local statutes which provide for custody/visitation guidelines. For example, the statute may provide that a parent is entitled to reasonable visitation rights as a presumption.³⁰⁴ Or the state may have specific statutory guidelines that must be used in determining the best interest of the child. Such guidelines were recently enacted in Michigan and are quite extensive.³⁰⁵

Rights of visitation will take into account many of the factors associated with custody which is why attorneys and judges should be versed in the statutory guidelines.³⁰⁶ Nonetheless, visitation differs from custody in that visitation is often granted to non-custodial parties, "even where it involves some inconvenience to the custodial parent and some objections from the child's point of view."³⁰⁷ Thus, grandparents, other siblings, psychological parents and additional third parties may have standing under state statutes or judicial decision to petition the court for visitation rights.³⁰⁸ In any situation, the essential question must be whether the child's best interest will be served. That question can best be addressed through a careful review of state statutes and decisions with an emphasis on eliminating any discrimination based on improper consideration of HIV or AIDS in custody or visitation hearings.

Perhaps this goal can best be accomplished through implementation of one of the recommendations made by the Watkins Report which suggests that "[s]tate and local social service agencies should train special case workers to be assigned to cases involving HIV infection. Caseloads should be small so that the case worker will be readily available to support the family in time of crisis."³⁰⁹ Above all, education

304. See WIS. STAT. ANN. § 767.245(1) (West 1981) (repealed 1987). Cf. *F.P.R. v. J.M.*, 137 Wis. 2d 197, 404 N.W.2d 530 (1987) (court held that word "parent" was too ambiguous and that person who has been in loco parentis is entitled to consideration for visitation rights).

305. MICH. COMP. LAWS ANN. § 722.23 (West Supp. 1988).

306. This is equally true with adoption and foster care placements. See, e.g., *D.A. v. D.R.L.*, 727 P.2d 768 (Alaska 1986) (father's consent to adoption not required under state statute); *In re J.J.J.*, 718 P.2d 948 (Alaska 1986) (affirmed trial court's interpretation of state statute).

307. H. CLARK, *supra* note 210, at 812.

308. States which have codified such rights include Alaska, California, Connecticut, Hawaii, Louisiana, Maine, Michigan, Ohio, Virginia and Washington. Freed & Walker, *supra* note 276, at 527. Courts are also accepting the possibility of giving custody rights to grandparents over parents. *Id.*

309. WATKINS REPORT, *supra* note 118, at 173. Special note should also be taken that of Admiral Watkins' recommendation that:

Social service agencies should undertake aggressive recruitment of foster families, including utilization of existing networks of foster parents in the community and publicity to focus public attention on these children and the need for foster homes. Agencies should consider non-traditional foster parents, including single and handicapped

must continue so that persons will know how HIV is transmitted and the limits on compelling state actions. Discrimination in relation to AIDS or HIV infection must be avoided as the Watkins Report recommends:

A strong anti-discrimination message, clarifying that HIV infection, like other disabilities, cannot be a basis for discrimination, should be a part of all national HIV education and information materials and activities, including the Centers' for Disease Control National AIDS Information and Education Program. In addition to providing the facts about transmission of the virus, national educational efforts should emphasize that HIV-related discrimination is both irrational and illegal. The federal government should provide leadership in asserting that HIV-related discrimination will not be tolerated.³¹⁰

Inclusion of such specific language in state statutes would assist in providing even further clarification to attorneys and judges regarding placement of children. At present some state statutes do provide guidelines for resolving issues such as custody, visitation, termination of parental rights, adoption and foster care. But even with these statutes there are frequent instances of abuse of discretion, which can only be rectified by appellate review. This takes time which is always an important factor in determining the best interest of a child. This interest would be better served through state statutes that specifically prohibited discrimination in connection with AIDS or HIV seropositivity.³¹¹

V. UNANSWERED ISSUES: HOW SHALL THE PERSPECTIVE ON THE AMERICAN FAMILY CONTINUE?

A. *Discrimination and the Threat of Time*

The Watkins Report makes a frequent and unambiguous recommendation to the President, federal government, state courts and legislatures, and the American family:

[E]ach act of discrimination, whether publicized or not, dimin-

individuals, older parents, and senior citizens for children with HIV infection.

Id.

310. *Id.* at 198.

311. Admiral Watkins writes:

Strong anti-discrimination laws are needed to establish a standard of behavior and to provide remedies in individual cases. In addition, because discrimination occurs in person-to-person interactions, eradicating it from our society will require programs and policies to educate people in order to change their attitudes. Through a combination of laws and education we can promote this change and create a society in which discrimination against those infected with HIV as well as those with other handicapping conditions is unacceptable.

Id. at 197.

ishes our society's adherence to the principles of justice and equality. Our leaders at all levels—national, state, and local—should speak out against ignorance and injustice, and make clear to the American people that discrimination against persons with HIV infection will not be tolerated.³¹²

This recommendation was accepted by the full Commission and sent to the President of the United States; it was endorsed by the American Medical Association and civil liberty advocates.³¹³ If adopted, it will result in new laws, new programs and new legal opinions. But will that be enough?

Because American family law is different from labor law and laws regarding the handicapped, the immediate answer is that a legislative response will not, by itself, be enough. Because of the continually changing family structure as well as the continually changing face of the AIDS virus, there are broad social issues at stake that cannot be addressed completely in any single law. These issues concern confidentiality, privacy, due process, equal protection and in general, the extent of government action in light of compelling evidence concerning the spread of the disease. Researchers predict that by 1992 there will be 442,000 cases of AIDS and society is rightfully concerned over the extent of transmission and the resulting morbidity and mortality. The medical community reiterates this concern like a Greek chorus: "It is clear that if a total effort is not developed and sustained, the impact on present-day America will be protean."³¹⁴ As always, the solution to the legal dilemma will result by balancing the individual's needs against the needs of society.

Discrimination has become the word of action. Some segments of society have called for mandatory involuntary testing of everyone and all infected persons quarantined. Others have recommended isolation of infected persons through tatoos. But there has never been any official public health recommendation towards the isolation or quarantine of HIV positive persons. Indeed, the Presidential Commission recommends just the opposite.³¹⁵ This is in consonance with the American Medical Association, which recommends widespread voluntary testing in addition to testing of military personnel, blood and organ donors, immigrants and prisoners.³¹⁶

312. *Id.* at 196.

313. See *AIDS Panel Recommends Law Banning Discrimination*, Wash. Post, June 18, 1988, at A2, col. 5; Wash. Post, June 19, 1988, at A16, col. 1.

314. Francis & Chin, *supra* note 243, at 1357.

315. The Report states: "Traditional public health quarantine is not well suited to the limitation of HIV transmission." WATKINS REPORT, *supra* note 118, at 120. Nonetheless, the Chairman does recommend criminal law to penalize intentional transmission. *Id.* at 218.

316. *AMA Rejects Bid for Wider Routine AIDS Testing*, Wash. Post, June 24, 1987, at A8, col. 1.

However, less odious forms of discrimination have surfaced as a result of HIV testing. On November 24, 1986, *The Washington Post* reported that an Indianapolis judge terminated a divorced father's right to visit his 2 year-old daughter because test results showed that he had been exposed to the AIDS virus. No symptoms of the disease were present. The judge reasoned that the father's visitation would not be in the best interest of the child.³¹⁷ The *Post* reported that "[c]ases of such discrimination are mushrooming nationwide in the areas of housing, insurance, employment, child custody and health care."³¹⁸

Adults are not the only ones to experience the discriminatory impact of HIV positive testing. Children have been excluded from school and certainly from playmates because of positive test results caused by blood transfusions or hemophilia. Indeed, after Fire Captain Jon Galihier gave mouth-to-mouth resuscitation to a dying person that was later revealed to be HIV infected, neighbors of the Fire Captain "actually withdrew their children off the street to avoid coming in contact with [his] children."³¹⁹ These children had not even tested positive.

Each day the list of grievances grows, especially as more and more persons lose their reluctance to come forward and be identified with the disease. Also, as advances in medical technology provide longer life expectancies, persons with AIDS Related Complex (ARC) continue to press for litigation to remedy past discrimination. The United States court system is designed to respond to discrimination, but it is not reasonable to expect an already over-burdened system to accommodate the number of cases that would be generated by involuntary testing, positive results, and the myriad forms of invidious discrimination that could result. Indeed, there is evidence that even beyond the physical and logistical difficulty of providing a forum to protect persons testing positive from the discrimination that could result, the judicial system is simply not designed to address immediate human suffering.

An example of the judicial system's inability to respond effectively to discrimination in the family law context is *Palmore v. Sidoti*,³²⁰ a case originating in Hillsborough County, Florida. In this case the non-custodial father sought custody of his daughter because the child's mother was presently living with a Negro, Clarence Palmore, Jr., whom she married two months later. The father of the girl made several allegations of instances in which the mother was not properly caring for the child, but the court stated: "there is no issue as to either party's devotion to the child, adequacy of housing facilities, or respectability of the new spouse

317. The judge's ruling was later overturned on appeal, but only after 19 months had passed. See *Stewart v. Stewart*, 521 N.E.2d 956 (Ind. App. 1988).

318. *AIDS Discrimination Issue Mushrooming*, Wash. Post, Nov. 24, 1986, at A1, col. 3.

319. *In re L.A. County Firefighters Local 1014 v. L.A. County Fire Dep't* No. UFC 5.14, slip op. (Oct. 6, 1986).

320. 466 U.S. 429 (1984).

of either parent."³²¹

Since there were few differences between the two parents, the court focused upon the interracial marriage of the mother and noted the counselor's recommendation in favor of a change in custody because "the wife . . . has chosen for herself and for her child, a life style unacceptable to the father *and to society*."³²² Thus, the court made the custody modification requested by the father and awarded custody of the now 4 year-old girl to him. The judge felt that this was in the best interest of the child because, "it is inevitable that Melanie will, if allowed to remain in the present situation and attains school age and thus more vulnerable to school pressure, suffer from the social stigmatization that is sure to come."³²³ The appellate Second District Court of Appeal of Florida affirmed the judge's decision without opinion and in 1983 the Supreme Court of the United States granted certiorari and heard the case.

The little girl was six years old when the Supreme Court heard the appeal from the mother. The mother's attorney argued that she and her husband had been victims of racial discrimination; the Florida Circuit Court judge had modified the original award of custody only because of her interracial marriage. There had been no evidence of misconduct and thus no reason to modify the original award of custody. Indeed, the Florida court made the award of custody to the father on no other ground besides racial discrimination.

Chief Justice Burger wrote for an unanimous Court: "Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect."³²⁴ The Court thus reversed the District Court of Appeal of Florida and remanded the case back to the Circuit Court of Hillsborough County. It was 1985 and the little girl was now eight years old. She had been living with her father and his new wife for the previous four years and she had been living in Texas for almost three years.

Because of the extended absence from Florida, the originating Florida court decided it no longer had substantial evidence concerning "care, protection, training and personal relationships,"³²⁵ and thus relinquished jurisdiction to Texas. The mother appealed and lost. If she is ever to regain custody of her daughter she is required to start all over again in Texas.

The *Palmore* facts illustrate the difficulty of judicial protection of human fundamental rights resulting from discrimination because of bias or prejudice. This is a recent case involving what has become a familiar theme in American jurisprudence: promotion of racial equality. Yet,

321. *Id.* at 432.

322. *Id.* at 431.

323. *Id.*

324. *Id.* at 433.

325. *Palmore v. Sidoti*, 472 So. 2d 843, 845-46 (Fla. Dist. Ct. App. 1985).

when a person sought to protect her interests, and her family's interests from discrimination, she won only to lose. She did what she was supposed to do, never kidnapping the child, progressing through the judicial sequence of events, paying her dues, awaiting what the unanimous Court implied, vindication by law. She achieved vindication, but lost what she really wanted, her daughter. Surely discrimination not so clear cut and implying contagion with a disease for which there is no cure, will be even more invidious than race. Any person involved with the judicial system must ask if that system will be able to address the possible discrimination. One thing is certain, the time required for the system to work would be too long in the average family law case involving all too human issues.

B. *Responsibilities of Professionals*

In recent years, a variety of groups have published guidelines and recommendations on how people, groups and especially professionals should respond to the crisis brought on by AIDS. The American Medical Association published three volumes entitled *Information on AIDS for the Practicing Physician*;³²⁶ the United States Catholic Conference published *The Many Faces of Aids: A Gospel Response*;³²⁷ the American Psychological Association published *Psychology and AIDS*³²⁸ with an excellent list of suggestions as to ethical conduct; and universities such as St. Mary's in San Antonio, Texas, published an official AIDS policy. Obviously, many segments of the population are responding to the challenge of this disease.

With the guidance of these publications and the recommendations contained within the Watkins Report, the following guidelines are suggested for attorneys engaged in a professional relationship with a person with AIDS:

1. Approach each client as a person without regard to accidental qualities of life-style or habits. Be open to the client's history, sense of urgency, and need for a managed medical and legal response to the on-going nature of the illness.
2. Inform the client that he or she may be required to complete an extensive medical examination, but that he or she has a right to privacy unless that right is voluntarily surrendered. Should it be surrendered, any information obtained could be disclosed on public documents or records.
3. Involve the client's family in a *living* situation, allowing that

326. AM. MED. A., INFORMATION ON AIDS FOR THE PRACTICING PHYSICIAN (1987).

327. 17 ORIGINS 481 (1987). See also W. AMOS, WHEN AIDS COMES TO CHURCH (1988).

328. AM. PSYCHOLOGICAL A., PSYCHOLOGY AND AIDS, ABSTRACTS FROM THE MINI-CONVENTION, 95TH ANNUAL CONVENTION 84-93 (1987).

family, in whatever form it may appear, to provide support and perspective. Be aware that you, as attorney, cannot be all things to all people.

4. Inform the client and his or her family that the media may publicize the suit.

5. Represent your client to your greatest professional capacity, including mediating with employers, landlords, co-workers, and others, seeking to employ the skills of mediation and counseling. Remember that you represent a person and not a crusade.

6. Inform your client of the difficulty he or she will encounter with seeking to fit new issues into old doctrines. Litigation is a long process and time can be a threat to human beings.

7. Be comfortable with death and dying. Read books on AIDS; read something your client reads each day.

8. Respect your client's agenda of living, but seek to inform your client of his or her legal options in preparing for death.

9. Allow your client a sense of humor, time to make decisions based on his or her personal convictions, and the chance to benefit from your legal advice.

10. Practice the best law possible, offering alternatives based on recently enacted statutes, judicial decisions and rulings.³²⁹

These ten guidelines should be read in such a way as to allow the even numbers to complement the odd numbers. But even taken as a whole, the guidelines do little more than serve as a reminder that perhaps the goal of the truly professional attorney is to allow the client "an effort to be autonomous."³³⁰

VI. CONCLUSION

A continuing perspective on the American family would suggest a number of important changes in just a short period of time. First, AIDS is certain to have an impact upon the unlimited possibilities that seemed so available just a few years ago. Perhaps not so much in the public social norms followed by persons, but in the more private choices of family relations, particularly sexual relations. This is true in the homosexual community. Literature associated with homosexuality constantly refers to the feast of good looks, dancing and unlimited possibility of sexual encounter just a few years ago. But, as the book's title suggests, "the band played on" so that by the mid-80's the best, brightest and most beautiful were dying an ignominious death that did not even have a

329. These guidelines first appeared in R. O'BRIEN, *supra* note 48, at 137-38.

330. A. BLOOM, *CLOSING OF THE AMERICAN MIND* 21 (1987).

name. That same band is playing as the disease flirts with the heterosexual community; it is a deafening din in the inner-city communities of America among the poor and the homeless, single parents and family-type homes. Certainly the endless possibilities offered to many are less than they once were and, as the disease affects children and infants, possibilities must be developed immediately. The message must be made clear that the ghettos of America's cities will be to persons living there what the gay bathhouses were to homosexuals in the late 70's.

The medical aspects of the disease are frightening. Phrases such as a family tree of virus, HIV-2, indefinite incubation period, lack of a vaccine and an explosion of new tests that can classify as well as diagnose are with us. Numbers of persons with or without the disease anesthetize and perhaps will only seem real when the person next door, perhaps a child, is infected, develops symptoms, then dies.

The Report of the Chairman of the President's Committee on the Human Immunodeficiency Virus Epidemic identifies many of the family and individual issues that will dominate the next decade with AIDS. Surely that same report will provide an agenda for federal, state and local governments and courts to address the discrimination that exists, the crucial problem of time, and the professional responsibility needed to be exerted if there is to be that "striking variation" in our health care system demanded. Surely that report, as it calls attention to all perspectives of the American family, will call attention to the best in adults so that this new virus can become history.

